

EXHIBIT 2



Deposition of:
Patrick Lappert, M.D.

September 30, 2021

In the Matter of:
Kadel, et al vs. Folwell

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1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

7 CIVIL ACTION NO.: 1:19-cv-272-LCB-LPA

9 MAXWELL KADEL, et al.

10 Plaintiffs

12 v.

14 DALE FOLWELL, et al.

15 Defendants

18 REMOTE VIDEOTAPED VIDEOCONFERENCE

19 DEPOSITION TESTIMONY OF:

20 PATRICK LAPPERT, M.D.

21 September 30, 2021

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1 I, Lane C. Butler, a Court
2 Reporter and Notary Public, State of
3 Alabama at Large, acting as Notary,
4 certify that on this date, pursuant to
5 the Federal Rules of Civil Procedure,
6 there came before me via remote
7 videoconference from Decatur, Alabama,
8 commencing at approximately 8:30 a.m.
9 Central, on the 30th day of September,
10 2021, PATRICK LAPPER, M.D., witness in
11 the above cause, for oral examination,
12 whereupon the following proceedings were
13 had:

14

15 THE VIDEOGRAPHER: Good morning.
16 We are going on the record at 8:31 a.m.,
17 Thursday, September 30th, 2021. This is
18 Media Unit 1 of the videorecorded
19 deposition of Dr. Patrick Lappert as
20 taken by counsel for plaintiff in the
21 matter of Kadel, et al. v. Folwell, et
22 al., filed in the United States District
23 Court for the Middle District of North

1 Carolina, Civil Action No.

2 1:19-cv-272-LCB-LPA.

3 This deposition is being
4 recorded remote via Zoom located in
5 Decatur, Alabama. My name is Andrew
6 Baker from the firm Veritext Legal
7 Solutions. I am the videographer. The
8 court reporter is Lane Butler, also from
9 Veritext Legal Solutions.

10 Will counsel now state their
11 appearance and affiliations for the
12 record. The court reporter will swear in
13 the witness. Thank you. We may proceed.

14 MR. TISHYEVICH: This is Dmitriy
15 Tishyevich from McDermott, Will & Emery,
16 LLP, for plaintiffs.

17 MR. KNEPPER: My name is John
18 Knepper. I represent three of the
19 defendants in this matter: the North
20 Carolina State Health Plan for Teachers
21 and State Employees; Dale Folwell, the
22 treasurer for the State of North
23 Carolina; and Dee Jones, the executive

1 administrator of the North Carolina State
2 Health Plan. I'll be defending Dr.
3 Lappert's deposition.

4

5 PATRICK LAPPERT, M.D.,
6 having first been duly sworn,
7 was examined and testified as follows:

8

9 EXAMINATION BY MR. TISHYEVICH:

10 Q. Good morning, Doctor.

11 A. Good morning, sir.

12 Q. State your full name for the
13 record.

14 A. Patrick Walter Lappert.

15 Q. Any reason you're not able to
16 give complete and truthful testimony
17 today?

18 A. There is no reason.

19 Q. You've been retained as an
20 expert by defendants in this case;
21 correct?

22 A. I have.

23 Q. You've prepared an expert

1 report; right?

2 A. I have.

3 Q. So, I've premarked Exhibit 1.

4 Open that, and let me know when you have
5 it.

6 (Exhibit 1 was marked for identification
7 and is attached.)

8 A. Okay. I have it.

9 Q. This report contains all the
10 opinions that you intend to offer in this
11 case; correct?

12 A. It does.

13 Q. All right. Without telling me
14 any conversations that you had with
15 counsel, what did you do to prepare for
16 your deposition today?

17 A. Well, I reviewed the -- the
18 documents. I guess it's called the
19 complaint. I reviewed the patient
20 records. And then, I reviewed the
21 literature, pertinent journal articles,
22 publications, and had conversations with
23 -- with counsel, Mr. Kadel [sic], and his

1 staff at various times.

2 Q. When you say "patient records,"
3 are you talking about the medical records
4 for the individual plaintiffs?

5 A. Yes. The ones that were -- that
6 were given to me to review.

7 Q. And when you say "the
8 literature," are you referring to some of
9 the studies that you cite in your report?

10 A. Yes.

11 Q. Have you reviewed any studies --
12 strike that.

13 In preparing for your deposition
14 today, have you reviewed additional
15 studies that are not cited in your
16 report?

17 A. No. The report contains all of
18 the studies that I -- that I reviewed
19 that I consider pertinent. I glossed
20 some but didn't see them as germane. So
21 all the ones that were -- that were
22 germane to my opinion are -- are in the
23 -- in the document.

1 Q. Understood. And you mentioned
2 that you met with or spoke with Mr.
3 Knepper in preparing for today?

4 A. I have.

5 Q. Okay. Again, without disclosing
6 any substance of the conversation, how
7 many times did you speak or meet with
8 him?

9 A. Three or four times, I think.

10 Q. And when did those conversations
11 take place?

12 A. Well, as recently as yesterday
13 evening and I think a couple of meetings
14 back in May, I think it was. I'd have to
15 look at my calendar, but.

16 Q. Last evening, you spoke --
17 strike that.

18 You know that Dr. Hruz was
19 deposed yesterday; right?

20 A. I'd heard, yes.

21 Q. And so before yesterday, when
22 was the last time that you spoke with Mr.
23 Knepper to prepare for your deposition?

1 A. I want to say it's a couple of
2 weeks ago. I'm not exactly sure.

3 Q. How long was the conversation
4 with Mr. Knepper last night?

5 A. A little less than an hour.

6 Q. Did he provide you with copies
7 of any of the exhibits that were used at
8 Dr. Hruz's deposition?

9 A. No, he did not.

10 Q. Did he provide you with any --
11 any portions of that deposition
12 transcript?

13 A. No.

14 Q. And then going in reverse
15 chronological order, you mentioned you
16 may have spoken a couple of weeks ago?

17 A. I think. I don't know exactly
18 -- I don't know exactly when that was,
19 Mr. Tishyevich. I want to say three
20 weeks ago perhaps. I'm not exactly sure.

21 Q. Do you recall roughly how long
22 that conversation was?

23 A. About the same duration. I

1 think it was perhaps an hour, perhaps an
2 hour.

3 Q. Okay. All right. You -- in the
4 course of -- strike that.

5 In the course of working on this
6 case, have you ever communicated with Dr.
7 Hruz?

8 A. Not directly. I've spoken with
9 Dr. Hruz, but in the matter at hand, I
10 have not spoken with him about it.

11 MR. TISHYEVICH: For the court
12 reporter, that's H-R-U-Z. And I'll try
13 and spell things as we go to make it a
14 little easier.

15 Q. How about Dr. McHugh?

16 M-C-H-U-G-H. Have you spoken with him in
17 the course of working on this case?

18 A. I've never spoken directly to
19 him, no.

20 Q. How about Dr. Levine?

21 L-E-V-I-N-E.

22 A. I have not spoken with Dr.
23 Levine.

1 Q. But you have met Dr. Hruz before
2 working on this case; right?
3

4 A. Yes.
5

6 Q. And is the same true for Dr.
7 Levine?
8

9 A. I've never met Dr. Levine.
10

11 Q. All right. About how many hours
12 do you estimate you've spent working on
13 your expert report?
14

15 A. Somewhere around maybe 60 hours.
16 I could -- I could look for that number,
17 but I'm going to estimate it at about 60
18 hours, something like that.
19

20 Q. You're aware that the individual
21 plaintiffs in this case have been
22 deposed; right?
23

24 A. Yes, I've heard.
25

26 Q. Were you provided with
27 deposition transcripts or any portion of
28 their testimony?
29

30 A. I have -- I have not seen those,
31 no.
32

33 Q. Okay. You're aware that other
34

1 experts in this case have also already
2 been deposed?

3 A. Yes.

4 Q. Have you been provided with
5 deposition transcripts or any portion of
6 their deposition testimony?

7 A. I -- I saw a transcript of Dr.
8 McHugh's.

9 Q. Was that the only tran- --
10 strike that.

11 Was Dr. McHugh's transcript the
12 only expert deposition transcript you've
13 seen?

14 A. It's the only one I've read. I
15 -- I think that -- yeah, I think it's the
16 only one I read. Yes, sir.

17 Q. Okay. All right. So throughout
18 your report, you use this term --

19 A. Could I amend that last answer?

20 Q. Of course.

21 A. I -- I did read portions of Dr.
22 Brown's transcript, actually, some days
23 back. My -- my apologies.

1 Q. No. And I should say that. If
2 at any point in time in your deposition
3 you want to go back and amend your
4 answer, that is totally fine.

5 A. Thank you.

6 Q. Okay. So in your report, you
7 use this term "transgender treatment
8 industry." Right?

9 A. Yes.

10 Q. And you and Dr. Levine and Dr.
11 McHugh all use this term in your reports.
12 Were you aware of that?

13 A. Oh, I was aware that the -- no,
14 I wasn't aware that they were using it,
15 actually.

16 Q. Is it coincidental that the
17 three of you are using this term?

18 A. I -- I think it's sort of
19 becoming a common term lately. I don't
20 know where it came from. I was trying to
21 think about that. I don't know who
22 originated it, but I've -- I don't know
23 even if it was me that originated it,

1 actually, since I've been speaking about
2 this subject for some time now. But it
3 seemed like an apt term, so it doesn't
4 surprise me that others are using it.

5 Q. You don't know who came up with
6 that term?

7 A. I don't.

8 Q. It's possible that it was you?

9 A. It wouldn't surprise me.

10 Q. And you mentioned that it's
11 becoming more commonly used. Is that
12 right?

13 A. It seems to be. I don't know.
14 I don't know how common it is, but it's
15 kind of a small circle of people talking
16 about these things.

17 Q. Are you aware of a single
18 peer-reviewed scientific article that has
19 used the term "transgender treatment
20 industry"?

21 A. I am not.

22 Q. Do you know what PubMed is?

23 P - U - B - M - E - D .

1 A. Yes.

2 Q. It's a search engine maintained
3 by the National Institute of Health;
4 right?

5 A. Yes. That's my understanding.

6 Q. It's a search engine for
7 scientific articles, basically; right?

8 A. Yes.

9 Q. So I'll represent to you that I
10 ran a search in PubMed for the phrase
11 transgender treatment industry, in
12 quotation marks, and came back with zero
13 results for that phrase.

14 MR. KNEPPER: Objection to form.

15 Q. Do you find that surprising?

16 A. No.

17 Q. Okay. What does that lack of
18 results tell you about whether this term
19 is a commonly used term in this field?

20 MR. KNEPPER: Objection to form.

21 A. I wouldn't expect it to be a
22 commonly used term, and it doesn't
23 surprise me that you didn't find it.

1 Q. Yeah. "Transgender treatment
2 industry" is not a commonly used term in
3 the field of treatment and diagnosis of
4 gender dysphoria; right?

5 MR. KNEPPER: Objection to form.

6 A. I would agree.

7 Q. Yeah. It's a term that, as far
8 as I can tell, is fairly idiosyncratic to
9 the opinions that you and the other
10 defendant experts are using in this case.
11 Does that sound right?

12 MR. KNEPPER: Objection to form.

13 A. That sounds right to me, yeah.

14 Q. Okay. Look at page 1 of your
15 expert report, Exhibit 1.

16 A. All right.

17 Q. I see it says, "Declaration of
18 Patrick Lappert, MD." You see that?

19 A. Yes.

20 Q. Under that, it says, "Board
21 Certified in Surgery and Plastic
22 Surgery." Do you see that?

23 A. I do.

1 Q. Let's talk about your
2 certifications. Let's start with plastic
3 surgery. You originally received your
4 board certification in plastic surgery in
5 1997; correct?

6 A. That's correct.

7 Q. Then you got recertified in
8 2008; correct?

9 A. That's correct.

10 Q. That board certificate was only
11 valid for ten years; correct?

12 A. Correct.

13 Q. And your plastic board -- strike
14 that.

15 And your plastic surgery board
16 certificate expired at the end of 2018;
17 correct?

18 A. Correct.

19 Q. Well, why did you decide not to
20 renew your board certificate past 2018?

21 A. Well, I'm a -- I'm a solo
22 practitioner, and the main reason for
23 maintaining that expensive certificate

1 was that many hospitals required it in
2 order to have privileges. Several years
3 ago, a lot of hospitals started dropping
4 that requirement, so it didn't make sense
5 for a surgeon who is within three years
6 of retirement to expend all that money
7 and time to maintain a certification that
8 was no longer necessary for me in terms
9 of maintaining my practice.

10 Q. Do you currently have admitting
11 privileges at any hospital?

12 A. No.

13 Q. When was the last time you had
14 admitting privileges in any hospital?

15 A. A year ago.

16 Q. What hospital was that?

17 A. Crestwood Hospital, Huntsville,
18 Alabama.

19 Q. So within the last year at
20 least, I take it you haven't performed
21 any surgeries at a hospital. Right?

22 A. That's correct. A -- a year
23 ago, I retired from active surgical

1 practice.

2 Q. Were you doing surgeries in 2019
3 after your plastic -- plastic surgery
4 board certificate expired?

5 A. Yes.

6 Q. When -- just can we pin this
7 down more? What -- what month do you
8 think you stopped performing surgeries?

9 A. Let's see. This is November of
10 2021, so it would have been August of
11 2020.

12 Q. All right. You are not
13 currently board-certified in plastic
14 surgery; correct?

15 A. Correct.

16 Q. And you have not been
17 board-certified in plastic surgery since
18 2018; correct?

19 A. Correct.

20 Q. For over two and a half years at
21 this point; right?

22 A. Correct.

23 Q. So this page 1 of your report

1 says that you're board-certified in
2 plastic surgery. Do you think it's
3 appropriate for you to make that
4 representation even though you don't have
5 an active certification?

6 MR. KNEPPER: Objection, form.

7 A. Well, appropriate in terms of --
8 I don't understand the question.

9 Q. Let me be more specific.

10 A. Okay.

11 Q. Do you know what the Amer- --
12 I'll go back.

13 You know what the American Board
14 of Plastic Surgery is; right?

15 A. Certainly.

16 Q. Do you know what the American
17 Board of Plastic Surgery has to say about
18 doctors who represent that they're
19 board-certified when they don't have an
20 active certification?

21 MR. KNEPPER: Objection, form.

22 A. They discourage it. I -- I
23 suspect that the -- the document -- well,

1 I didn't prepare that -- that particular
2 part of the document, although I signed
3 it, certainly. But I see your point,
4 yes.

5 Q. Okay. I'm going to introduce
6 another exhibit. You'll see it in a
7 minute. Let me know when you have it,
8 Doctor.

9 (Exhibit 2 was marked for identification
10 and is attached.)

11 A. I have it.

12 Q. This is a printout from the -- a
13 web page from the American Board of
14 Plastic Surgery. Go to page 2.

15 A. All right. I'm there.

16 Q. Middle of the page, it says in
17 bold letters, "Guidelines for Stating
18 Certification Status." Do you see that?

19 A. I do.

20 Q. Look at the third paragraph.

21 A. All right.

22 Q. It says, "ABPS does not mandate
23 the specifics of how diplomates state

1 their certification, except to assert
2 that diplomates should not state or imply
3 that they are certified if their
4 certification has expired."

5 Do you see that?

6 A. I do.

7 Q. All right. You understand that
8 under this guidance from the ABPS, you
9 are not supposed to be representing that
10 you are board-certified in plastic
11 surgery because you do not have a current
12 certification; correct?

13 MR. KNEPPER: Objection, form.

14 A. Yes, I understand it.

15 Q. Let's look at what else it says.
16 Towards the bottom of page 2, it says,
17 "We ask that you follow these guidelines
18 throughout your career to accurately
19 state your ABPS certification." Do you
20 see that?

21 A. I do.

22 Q. The first bullet says,
23 "Diplomates of ABPS must accurately state

1 their certification status at all times."

2 Do you see that?

3 A. I do.

4 Q. And you understand what this
5 means; right?

6 A. I do.

7 MR. KNEPPER: Objection, form.

8 Q. Page 3, next bullet says,
9 "Diplomates with expired time-limited
10 certification or those whose
11 certification is revoked may not claim
12 Board certification by ABPS and must
13 revise all descriptions of their
14 qualifications accordingly." Right?

15 MR. KNEPPER: Objection to form.

16 A. Yes. Yes, I see that.

17 Q. And you understand what that
18 means; right?

19 MR. KNEPPER: Objection to form.

20 A. I do.

21 Q. Your expert report is not in
22 compliance with this guidance from the
23 ABPS; correct?

1 MR. KNEPPER: Objection, form.

2 A. The -- the one line there under
3 my name is not in compliance. That's
4 correct.

5 Q. And the same is true of your CV;
6 right?

7 A. Well, the CV states that I have
8 been board-certified by the American
9 Board of Surgery and have been
10 board-certified by the ABPS in 1997 and
11 2008, yes. Have been.

12 Q. And look back at this page 3
13 from the ABPS. It says, "When a
14 physician misrepresents certification
15 status, ABPS may notify local
16 credentialing bodies, licensing bodies,
17 law enforcement agencies and others." Do
18 you see that?

19 A. I do.

20 Q. All right. And you understand
21 what this means; right?

22 MR. KNEPPER: Objection to form.

23 A. Yes.

1 Q. Okay. Are you going to update
2 your expert report so that it comports
3 with this guidance from the ABPS?

4 MR. KNEPPER: Objection to form.

5 A. Certainly.

6 Q. Okay. So that's plastic
7 surgery. Let's talk about your board
8 certification in surgery next. So, go
9 back to your expert report, page 1.

10 A. Okay.

11 Q. You received your board
12 certification in surgery in 1992;
13 correct?

14 A. Was it '92 or '91? '92, yes,
15 sir.

16 Q. And that certification expired
17 in 2002; right?

18 A. Yes.

19 Q. And you had not renewed that
20 after 2002; right?

21 A. Correct.

22 Q. You're not currently
23 board-certified in surgery; correct?

1 A. Correct.

2 Q. You have not been
3 board-certified in surgery since 2002;
4 correct?

5 A. Since 2002, yes, sir.

6 Q. That's over nineteen years;
7 right?

8 So, I showed you this guidance
9 from the American Board of Plastic
10 Surgery. How about the American Board of
11 Surgery? What do you think they have to
12 say about doctors who make these kind of
13 representations?

14 MR. KNEPPER: Objection, form.

15 A. I'm sure it's probably the same.

16 Q. Yeah. Would it surprise you
17 that the American Board of Surgery does
18 not allow doctors to represent that they
19 are board-certified in surgery unless
20 they have a current board certificate?

21 MR. KNEPPER: Objection, form.

22 A. It would not surprise me, no.

23 Q. All right. You are currently

1 serving as an expert in another case,
2 Brandt v. Rutledge. B-R-A-N-D-T.

3 Correct?

4 A. Yes.

5 Q. That's a case pending in federal
6 court in Arkansas; right?

7 A. Correct.

8 Q. In that case, you were retained
9 by the defendants, by the State of
10 Arkansas; right?

11 A. Yes.

12 Q. Dr. Hruz, who is one of the
13 defendants -- strike that. Dr. Hruz, who
14 is one of the experts in this case, is
15 also serving as an expert for defendants
16 in that Brandt case; right?

17 A. That's my understanding, yes.

18 Q. And the same is true for Dr.
19 Levine; right?

20 A. I didn't know about Dr. Levine,
21 but.

22 Q. And you submitted an expert
23 declaration in that Brandt case in July

1 of this year; correct?

2 A. I believe that was when I
3 submitted it, yes.

4 Q. All right. Let's look at it.
5 And let me know when you get the exhibit,
6 Doctor.

7 (Exhibit 3 was marked for identification
8 and is attached.)

9 A. Here it is. Let's see. All
10 right.

11 Q. All right. Page 1 says,
12 "Declaration of Dr. Patrick Lappert."
13 That's you; right?

14 A. Yes.

15 Q. Fair to say that there is at
16 least some overlap between the opinions
17 that you're offering in this case and the
18 opinions that you're offering in that
19 Brandt case; right?

20 MR. KNEPPER: Form.

21 A. Well, given that the subject
22 matter is the same, I would expect some
23 overlap, yes, sir.

1 Q. Go to page 5 of that
2 declaration.

3 A. All right. I'm there.

4 Q. You say under Section II,
5 "Gender affirming' treatments are
6 experimental." Right?

7 A. Yes.

8 Q. It's basically the same opinion
9 that you offered in this case; right?

10 A. Yes, sir.

11 Q. Go to page 29 of your
12 declaration. See there's a paragraph 63?

13 A. Yes, sir.

14 Q. And toward the end of that
15 paragraph, you talk about the national
16 reviews in England, Sweden, and Finland
17 and other reviews like Cochrane, Griffin,
18 and Carmichael. You see that?

19 A. Yes, sir.

20 Q. You relied -- you relied on all
21 those studies for your opinions in this
22 case as well; right?

23 A. I did.

1 Q. Okay. Go to page 38 of your
2 declaration. Do you see that it's the
3 section titled "Concluding Opinions" and
4 it goes through the next --

5 A. Yes, sir.

6 Q. -- few pages?

7 We don't need to go through
8 these individually, but you agree there's
9 a lot of overlap between the opinions
10 you're offering in that Brandt case and
11 the opinions you're offering in this
12 case; right?

13 MR. KNEPPER: Objection to form.

14 A. Yes.

15 Q. The Brandt case involves a
16 challenge to an Arkansas law which bans
17 doctors from providing various types of
18 gender-affirming treatments to
19 adolescents; correct?

20 A. Yes.

21 Q. Including puberty blockers and
22 cross-sex hormones and gender-affirming
23 surgery; correct?

1 A. Yes.

2 MR. KNEPPER: Objection.

3 Q. Have you kept up with what's
4 going on in that case in Arkansas?

5 MR. KNEPPER: Objection, form.

6 A. I haven't heard anything perhaps
7 in the last several weeks.

8 Q. Well, are you aware that in July
9 of this year, the judge in that case held
10 that the State is prohibited from
11 enforcing the ban while the case is being
12 decided?

13 A. I've heard that.

14 Q. All right. And as part of that
15 order, the judge made some factual
16 findings. Are you aware of that?

17 A. I'm not -- haven't read the
18 details.

19 Q. All right. Let me show you.

20 A. Okay.

21 Q. Let me introduce one more
22 exhibit.

23 (Exhibit 4 was marked for identification

1 and is attached.)

2 A. I have it now.

3 Q. Okay. So, this is a
4 supplemental order from Judge Moody in
5 Arkansas dated August 2nd, 2021. Do you
6 see that?

7 A. I see that, yes.

8 Q. This first paragraph says,
9 "After further consideration, the Court
10 supplements the ruling made at the
11 conclusion of the July 21, 2021 hearing
12 to include the following findings." Do
13 you see that?

14 A. I do.

15 Q. By the way, did you testify live
16 at that July 2021 hearing?

17 A. No.

18 Q. Do you know if any of the other
19 experts testified live at that hearing?

20 A. I don't know.

21 Q. Go to page 7.

22 A. All right.

23 Q. All right. Look at the last

1 paragraph.

2 A. Okay.

3 Q. The second sentence in that last
4 paragraph says, "Gender-affirming
5 treatment is supported by medical
6 evidence that has been subject to
7 rigorous study." Right? Do you see
8 that?

9 A. That's what it says, yes, sir.

10 Q. And that finding by the Court in
11 Arkansas is contrary to the opinions that
12 you offered in that case; right?

13 A. Apparently so, yes.

14 Q. And it's also contrary to the
15 opinions that Dr. Hruz and Dr. Levine
16 offered in that case; right?

17 A. Yes.

18 MR. KNEPPER: Objection to form.

19 A. It appears to be, yes.

20 Q. And it's also contrary to the
21 opinions that you and Dr. Hruz and Dr.
22 Levine are offering in this case; right?

23 A. Yes.

1 Q. Look at the next sentence. It
2 says, "Every major expert medical
3 association recognizes that
4 gender-affirming care for transgender
5 minors may be medically appropriate and
6 necessary to improve the physical and
7 mental health of transgender people."

8 That's what it says; right?

9 A. That's what it says, yes, sir.

10 Q. That's also contrary to the
11 opinions that you and Dr. Hruz and Dr.
12 Levine are offering in both these cases;
13 right?

14 A. Yes, it certainly is.

15 Q. In fact, according to this
16 order, every major expert medical
17 association disagrees with you because
18 they've all taken a position that this
19 treatment is in fact medically necessary;
20 right?

21 MR. KNEPPER: Objection to form.

22 A. Apparently so, yes.

23 Q. All right. Look at page 6.

1 Look at the last paragraph. You see it
2 says that -- the third sentence says,
3 "The consensus recommendation of medical
4 organizations is that the only effective
5 treatment for individuals at risk of or
6 suffering from gender dysphoria is to
7 provide gender-affirming care." Do you
8 see that?

9 A. I do.

10 Q. You see there's a Footnote 3?

11 A. Let me get my glasses on here.

12 Footnote 3. I don't see Footnote 3.

13 Let's see.

14 Q. The bottom of page 6.

15 A. I see it now, yes.

16 Q. Footnote 3 has a long list of
17 medical organizations that all have taken
18 the position that gender-affirming care
19 is medically appropriate for individuals
20 with gender dysphoria; right?

21 MR. KNEPPER: Objection to form.

22 A. Yeah, the consensus
23 recommendations. Those are consensus

1 recommendations. And yes, I was aware
2 that those were the positions taken by
3 those organizations even before the
4 judge's opinion.

5 Q. Yeah. By my count, Footnote 3
6 lists 18 different professional medical
7 organizations, and as I read this
8 footnote, every single one of them takes
9 the view that's contrary to the opinions
10 that you and Dr. Hruz and Dr. Levine are
11 offering; right?

12 MR. KNEPPER: Objection to form.

13 A. Yes. There's a consensus of
14 consensus on this, exactly, yes, sir.

15 Q. And you're not aware of a single
16 professional medical organization that
17 submitted anything in this Brandt case
18 and said that they agree with the
19 opinions that you and Dr. Hruz and
20 Dr. Levine are offering; right?

21 A. Well, I'm aware of at least one
22 professional organization that -- that
23 disagrees with that, yeah, the

1 pediatric -- American Pediatric --
2 American Association of Pediatricians.

3 Q. Do you know if they submitted
4 anything to the Court in this Brandt case
5 to that effect?

6 A. I'm not aware. I don't know.

7 Q. Okay. Look back to your report,
8 Exhibit 1.

9 A. Okay.

10 Q. And go to page 5.

11 A. Okay.

12 Q. See there's paragraph 11?

13 A. Yes.

14 Q. And you say that "Affirmation
15 Treatments are Currently Experimental."
16 And then you say, "are not generally
17 accepted by the relevant scientific
18 community." Right?

19 A. Yes, I say that, absolutely.

20 Q. Well, apparently, there's at
21 least eighteen different professional
22 medical organizations that all say that
23 you and Dr. Hruz and Dr. Levine are wrong

1 and that these gender-affirming
2 treatments are, in fact, medically
3 appropriate; right?

4 A. Well, I --

5 MR. KNEPPER: Object.

6 A. I would say that part of the
7 difficulty here is a misunderstanding
8 about how those consensus opinions are
9 arrived at. They're not arrived at
10 scientifically. So minus a scientific
11 opinion, those are -- those are consensus
12 opinions.

13 For example, in plastic surgery,
14 there was a controversy some years ago
15 about the use of fat grafting in breast
16 reconstruction, and there was a concern
17 about whether it would promote malignant
18 degeneration. The American Society of
19 Plastic and Reconstructive Surgeons came
20 out with a consensus statement
21 essentially recommending against, if not
22 outright forbidding, the use of fat
23 grafting in breast reconstruction or

1 cosmetic surgery. But I was never
2 polled. I was a member of the American
3 Society of Plastic Surgery, but I was
4 never polled.

5 These consensus statements do
6 not poll the scientific or professional
7 community. They're the work product of
8 a -- of small committees where they
9 perhaps will review scientific literature
10 and come to an opinion within that
11 relatively small group.

12 So I think the misunderstanding
13 is that because, for example, the
14 American Medical Association or the
15 American Pediatric Society has a
16 statement making this claim, it's not, by
17 definition, supported by the membership
18 of that -- that society. It is the work
19 product of a committee, and it's -- and
20 it doesn't -- it doesn't lay out the
21 scientific basis for those opinions for
22 the membership to review, as was the case
23 in -- and it turns out that seven, eight

1 years later, the American Society of
2 Plastic and Reconstructive Surgery
3 rescinded their prohibition when the
4 membership basically chimed in and said
5 this is incorrect and this is our
6 evidence, here's the science. And the
7 American Society rescinded that consensus
8 statement that they had made ten years
9 earlier.

10 So I imagine that similar things
11 are going on here. Committees generates
12 consensus statements. The consensus
13 statements are published. And one gets
14 the impression that the entire membership
15 supports the statement when that in fact
16 is not the case. And when these
17 consensus statements are published, they
18 don't publish the supporting scientific
19 literature. They merely make the
20 statement. So I think this is the case
21 here as well.

22 Q. You are not a member of the,
23 let's say, American Medical Association;

1 right?

2 A. Not -- not any longer, no.

3 Q. And your -- I hear you
4 speculating that there's a committee that
5 came to this decision at the AMA; right?

6 MR. KNEPPER: Objection, form.

7 A. Well, if the AMA functions like
8 the American Society of Plastic Surgery
9 or other -- other professional bodies
10 like that, professional organizations
11 like that, I would expect that's how they
12 make their consensus statements, yes.

13 Q. You personally do not know how
14 the AMA came to issue this consensus
15 statement, do you?

16 MR. KNEPPER: Objection.

17 A. I have no personal knowledge,
18 no.

19 Q. You have no personal knowledge
20 what scientific literature they reviewed
21 in coming up with that consensus
22 statement, do you?

23 A. That's the difficulty. Yes,

1 sir.

2 Q. Yeah.

3 A. Correct.

4 Q. You have no idea, in short, how
5 the AMA came to reach this consensus
6 statement; right?

7 MR. KNEPPER: Objection to form.

8 A. I have no personal knowledge of
9 it, no.

10 Q. How about the American Pediatric
11 Society? You're not a member of that;
12 right?

13 A. No.

14 Q. You have no idea how the
15 American Pediatric Society came to
16 support this consensus statement; right?

17 A. Well, in that case, I do have
18 friends who are members of the American
19 Pediatric Society, I think it is. And
20 they, in conversation, have told me that
21 this is how the process works. I don't
22 have personal -- personal knowledge of
23 it, no.

1 Q. Are those friends on the
2 committee at the APA that decided to
3 adopt this consensus statement?

4 A. Not to my knowledge.

5 Q. So they also -- strike that.

6 How about the American
7 Psychiatric Association? You're not a
8 member of that --

9 A. No.

10 Q. -- right?

11 A. No.

12 Q. You have no idea on what basis
13 they decided to support this consen- --
14 what you call consensus -- consensus
15 statement about the necessity of
16 treatment for gender dysphoria, do you?

17 A. No.

18 Q. So, Doctor, I hear you
19 criticizing these organizations, but you
20 do not have firsthand knowledge of how
21 any of those organizations came to reach
22 these positions, do you?

23 MR. KNEPPER: Objection to form.

1 A. No.

2 Q. And you do not know what
3 scientific literature they relied on, do
4 you?

5 A. No.

6 MR. KNEPPER: Objection to form.

7 A. Other than to say that I'm
8 familiar with the current literature, and
9 I -- and whenever these -- these
10 consensus statements are supported with
11 references to the scientific literature,
12 that literature I have reviewed. That
13 was part of the process of generating my
14 expert testimony.

15 Q. I thought I just heard you say
16 that these position statements are not
17 typically supported by "Here's the study
18 we relied on." Isn't that what you said?

19 A. Well, no. In the -- in the
20 actual document that they publish, they
21 make -- they make reference to things
22 like that.

23 What I meant to say, I suppose,

1 is that -- that I've reviewed the current
2 literature, particularly in the last
3 three to five years, that's germane to
4 the subject of gender affirmation in
5 pediatric patients and adolescents, and
6 I -- and I find that the science is weak,
7 so --

8 Q. But because you have no
9 firsthand knowledge of how any of these
10 associations came out with these position
11 statements, you do not know to what
12 extent it may have taken that literature
13 into account before adopting these
14 position statements; right?

15 MR. KNEPPER: Objection.

16 A. I can only say that if they gave
17 full force to the scientific literature
18 that is used to support their position, I
19 find the scientific literature weak,
20 yeah.

21 Q. This Brandt case involves a
22 state law that prohibits doctors in
23 Arkansas from providing gender-affirming

1 medical treatment to anyone under
2 eighteen; correct?

3 A. Yes.

4 Q. You yourself support these kind
5 of state law bans; right?

6 MR. KNEPPER: Objection, form,
7 scope.

8 A. I do support a control over
9 these kinds of therapies, yes, I do.

10 Q. Well, not -- not just control,
11 because Arkansas says it will criminally
12 prosecute doctors that do it; right?

13 A. Right.

14 MR. KNEPPER: Objection to form,
15 scope.

16 Q. And you think that's a good
17 idea; right?

18 A. I do.

19 MR. KNEPPER: Objection to form,
20 scope.

21 Q. You think that other states
22 outside of Arkansas should be passing
23 similar bans; right?

1 MR. KNEPPER: Objection, form,
2 scope.

3 A. Actually, what I would prefer to
4 see is the -- is the professional
5 societies recommend against these sorts
6 of things, yes. That would be my
7 preference. I would rather that the
8 State did not step in and manage the care
9 of people who are suffering. I'd rather
10 the State stayed out of it. But short of
11 that, I suppose that's the -- the
12 fallback position is to recourse through
13 the law.

14 It would seem to me that
15 professional organizations should be
16 managing these issues, and practitioners
17 ultimately should be responsible, as was
18 found in the -- in the -- the case in
19 Great Britain at the Tavistock Portman
20 Institute when the Court came back and
21 reviewed the find -- the ruling there and
22 declared that primacy should be given to
23 the decision-making of doctors rather

1 than the Courts stepping in as -- as
2 managers of medical care.

3 And I feel the same way. I
4 don't think that the State should have to
5 do this. But -- given that -- given that
6 things are moving at the pace they are.

7 Q. Are you aware that state
8 legislators in Utah have proposed a
9 similar ban as Arkansas for
10 gender-affirming medical treatment for
11 minors?

12 A. Yes.

13 MR. KNEPPER: Objection to form,
14 scope.

15 Q. You had involvement with those
16 legislative efforts in Utah, didn't you?

17 A. I think I made some
18 recommendations to them. Yes, I did.

19 Q. Yeah. Because now I hear you
20 saying you prefer the professional
21 organizations handle it. But the fact is
22 you have actively lobbied to get these
23 kind of bans passed in other states,

1 haven't you?

2 A. Yes, I have.

3 MR. KNEPPER: Objection to form,
4 scope.

5 A. Yes, I have.

6 Q. I'm going to introduce another
7 exhibit. Let me know when you have it,
8 Doctor.

9 (Exhibit 5 was marked for identification
10 and is attached.)

11 A. I have it.

12 Q. Exhibit 5 is a document titled:
13 "Transgender 'Transition' Procedures
14 Performed on Minors. Answers to
15 Questions and Information for Joint
16 Interim Committee," dated June 10th,
17 2021. Do you see that?

18 A. I do.

19 Q. It says, "Submitted by Rep Rex
20 P. Shipp," S-H-I-P-P. Do you know who
21 that is?

22 A. I don't know him personally, but
23 I -- I see he's a representative from

1 Utah apparently.

2 Q. Have you ever communicated with
3 Mr. Shipp and his staff?

4 A. I may have and don't recall.

5 Q. Why do you say you may have?

6 A. I have a lot of correspondence
7 with people who ask a lot of questions
8 who are involved in this -- in this
9 issue, and I don't have a great memory
10 for names sometimes. But I know I was in
11 communication at some level with people
12 in Utah, but I don't recall exactly the
13 nature of that conversation, or that
14 interchange.

15 Q. Go to page 16.

16 A. Sixteen?

17 Q. One six.

18 A. One six. Okay.

19 Q. Toward the bottom of the page,
20 it says, "We express appreciation to
21 these noted professionals who contributed
22 to this report." Do you see that?

23 A. I do.

1 Q. Go to page 17.

2 A. Okay.

3 Q. The bottom of the page says,
4 "Patrick Lappert, M.D."

5 A. Yes.

6 Q. That's you; right?

7 A. Yes.

8 Q. So at some point earlier this
9 year, you were providing information to
10 the Utah State Legislature to support the
11 potential enactment of a ban on
12 gender-affirming healthcare for minors;
13 right?

14 MR. KNEPPER: Objection, form.

15 A. Yes.

16 Q. Look at the fourth name from the
17 bottom on page 17.

18 A. Fourth name -- I'm sorry?

19 Q. Fourth name from the bottom.

20 A. Paul Hruz. Yes.

21 Q. That's the same Dr. Hruz who's
22 an expert in this case; right?

23 A. Yes.

1 Q. Go to page 18. The second name
2 from the top is Stephen B. Levine M.D.;
3 right?

4 A. Yes.

5 Q. Same Dr. Levine who is an expert
6 in this case; right?

7 A. Yes. I think so, yes.

8 Q. And the next name is Paul
9 McHugh, M.D.; right?

10 A. Yes.

11 Q. The same Dr. McHugh who is an
12 expert in this case; right?

13 A. Yes.

14 Q. All four of you were providing
15 information to the Utah State Legislature
16 to support this potential ban; right?

17 MR. KNEPPER: Objection to form.

18 A. Yes.

19 Q. How did you get involved with
20 providing this information to the Utah
21 State Legislature?

22 A. I don't recall. My -- my
23 suspicion is I may have been contacted by

1 e-mail or some other such thing. In
2 fact, I'm fairly confident it was an
3 e-mail request for assistance, probably.

4 Q. Do you remember who the e-mail
5 was from?

6 A. I do not.

7 Q. Do you remember who at the Utah
8 State Legislature or anyone affiliated
9 with them you were communicating with in
10 this respect?

11 A. I don't remember, no.

12 Q. All right. Let's see what you
13 were telling the state legislature in
14 this report. Go to page 5. See there's
15 a section near the top titled "Sex
16 reassignment surgeries"?

17 A. Yes.

18 Q. There's some language in quotes
19 -- in quotes and italicized. Do you see
20 that?

21 A. I do.

22 Q. And the first portion of the
23 paragraph says: '"Sex reassignment

1 surgery' is a massive misrepresentation
2 of what these operations actually do.
3 You can't change a person's sex. All
4 that is happening is that the patient is
5 undergoing an intentional mutilation in
6 order to create a counterfeit appearance
7 of the other sex."

8 Do you see that?

9 A. I do.

10 Q. And underneath, it says,
11 "Patrick Lappert, M.D." Right?

12 A. Yes.

13 Q. These are your words, Dr.
14 Lappert; right?

15 A. Yes.

16 Q. You consider gender reassignment
17 surgery to be an intentional mutilation;
18 right?

19 A. I do. Absolutely.

20 MR. KNEPPER: Form.

21 Q. And calling gender reassignment
22 surgery, quote, intentional mutilation,
23 is that commonly accepted terminology in

1 this field, Doctor?

2 A. I expect not.

3 Q. And then you say that when a
4 patient undergoes gender reassignment
5 surgery, all that is happening is, quote,
6 a counterfeit appearance of the other
7 sex; right?

8 A. Yes.

9 Q. This phrase, "counterfeit
10 appearance," do you think that's an
11 appropriate term for a doctor to use?

12 A. Absolutely.

13 Q. And you stand by these words;
14 right?

15 A. I do.

16 Q. All right. So, we've talked
17 about Arkansas, we've talked about Utah.
18 Now, I know there is currently a number
19 of other states that are considering
20 passing similar bans. Outside of Utah,
21 have you done any work whatsoever in
22 connection with these potential bans in
23 other states?

1 MR. KNEPPER: Objection, form,
2 scope.

3 A. I have.

4 Q. Which states?

5 A. Alabama, Texas.

6 Q. What else?

7 A. Texas. I don't know if there
8 were any in the Northwest or not. I
9 think that's all of them. I may be
10 wrong, but I think that's all. Alabama
11 and Texas I would just add to your list.

12 Q. Okay.

13 A. There may been something in
14 Arizona. I'm not certain about Arizona
15 as well, but --

16 Q. Now let me introduce another
17 exhibit. Okay. Let me know when you get
18 this one.

19 (Exhibit 6 was marked for identification
20 and is attached.)

21 A. I've got it.

22 Q. All right. This article is
23 titled, "Alabama bill that would

1 criminalize treatment for transgender
2 minors headed to full Alabama Senate."

3 You see that?

4 A. I do.

5 Q. Alabama, your home state, was
6 considering a ban very similar to
7 Arkansas just this year; correct?

8 A. Actually over the last couple of
9 years.

10 Q. Okay. The first paragraph says,
11 "The Alabama Senate Health Committee on
12 Wednesday approved a bill that would
13 outlaw puberty-blocking medications and
14 gender-affirming care for minors,
15 giving" -- "giving it a favorable report
16 in an 11-2 vote." You see that?

17 A. I do.

18 Q. Then it says, "An Alabama House
19 committee heard testimony in a public
20 hearing on a companion bill, but the
21 committee did not vote on the" -- "on the
22 measure." You see that?

23 A. I do.

1 Q. You testified in support of this
2 bill; right?

3 A. Yes, sir.

4 Q. Go to page 2.

5 A. Okay.

6 Q. Look at the second paragraph
7 from the bottom.

8 A. Second from the bottom. Yes.

9 Q. It says, "Dr. Patrick Lappert, a
10 Decatur plastic surgeon, spoke in favor
11 of the bill."

12 That's you; right?

13 A. That's right.

14 Q. Go to page 3.

15 A. Okay.

16 Q. And look at the third paragraph.
17 It says that you've "spoken against the
18 use of medicine and surgery for
19 transgender people as a Catholic deacon
20 in his local diocese." See that?

21 A. Yes.

22 Q. You don't deny that you've
23 spoken against the use of medical and

1 surgical treatment for transgender people
2 in your position as a Catholic deacon;
3 right?

4 A. That's correct, I do not.

5 Q. All right. Focus on the last
6 sentence of this third paragraph. It
7 says that when a committee member
8 questioned your medical expertise on this
9 issue, you said that you would not treat
10 a person for gender dysphoria and would
11 instead refer them to a qualified mental
12 health professional. You see that?

13 A. Yes.

14 Q. At this hearing, someone on the
15 committee was questioning your medical
16 expertise to offer these opinions; right?

17 MR. KNEPPER: Objection, form.

18 A. I don't remember that detail,
19 but I think so, yeah. I think the
20 objection they raised was that I don't do
21 these treatments, how could I know.

22 Q. You're not a psychiatrist;
23 right?

1 A. No.

2 Q. You do not have specialized
3 training or expertise in diagnosing
4 mental health conditions; right?

5 A. I have limited -- limited
6 training. Yes.

7 Q. And when you say "limited
8 training," what does that mean?

9 A. Well, in the training of plastic
10 surgeons, we are -- we are required --
11 because we offer aesthetic surgery, we
12 get some training in issues,
13 psychological/psychiatric issues relating
14 to people who will seek to modify their
15 bodies in order to achieve a sense of
16 peace or a sense of improvement in their
17 lives. And it's imperative that a
18 plastic surgeon be able to recognize
19 persons who are suffering from
20 psychiatric problems because plastic
21 surgery -- to offer them plastic surgery
22 to modify their bodies is in the category
23 of malpractice, not to mention that very

1 often, dissatisfied patients will -- will
2 make life very difficult for the
3 practitioner, if not threaten them with
4 physical harm.

5 I would refer you to an article
6 by -- although we haven't offered it up,
7 -- a friend of mine, Dr. Mark Gorney, who
8 was one of the -- one of the grand old
9 men of plastic surgery, started the
10 Physicians Company to manage physician
11 liability and risk and had -- he
12 discovered that there's an
13 overrepresentation of -- of violence
14 against physicians by aesthetic patients
15 committing violence against plastic
16 surgeons. That's just one of the
17 motivators.

18 But nonetheless, the issue of
19 body dysmorphic disorder is part of our
20 training, persons who are seeking a
21 remedy to their interior woundedness or
22 their psychological disturbances by
23 changing their outward opinion. And body

1 dysmorphic disorder is a
2 well-characterized psychiatric diagnosis
3 that impinges greatly upon plastic
4 surgery precisely because aesthetic
5 surgery -- even in its name, you can tell
6 that aesthetic surgery is surgery aimed
7 at the aesthetic, the feelings, esthesia,
8 the feelings that a patient has about
9 themselves, about their life. So it's
10 incumbent upon plastic surgeons to know
11 about these things, and so we get trained
12 in those matters.

13 So again, I have very limited
14 psychiatric/psychological knowledge, but
15 I do know that that subset of patients
16 should be referred for psychological help
17 rather than offered surgery. Not to
18 mention the fact that such patients can't
19 even give informed consent because of
20 their psychological disturbances.

21 Q. All right. You're talking about
22 patients who have body dysmorphic
23 disorder; right?

1 A. That's right.

2 Q. When did you last receive
3 training in how to diagnose someone with
4 body dysmorphic disorder?

5 A. I guess it's ongoing training
6 when one's in the -- in the practice of
7 plastic surgery. But I had originally in
8 my residency and then on an ongoing basis
9 I think at conferences through the years.

10 Formal training in it, I -- I
11 don't recall beyond my residency. All I
12 do is try to keep abreast of the
13 literature.

14 Q. Yeah. So, let's take that in
15 steps. Outside of -- when was your
16 residency in plastic surgery, Doctor?

17 A. '92 to '94.

18 Q. Right. Past '94, you have not
19 received formal training in how to
20 diagnose someone with body dysmorphic
21 disorder; right?

22 A. There may have been some CME
23 credits at a conference in there

1 somewhere or remote learning. I don't
2 recall.

3 Q. But sitting here, you can't
4 recall any of those specifically; right?

5 A. I cannot, no.

6 Q. What are the diagnostic criteria
7 for body dysmorphic disorder?

8 A. Well --

9 Q. Do you know that sitting here
10 today?

11 A. Yes. So, a person with body
12 dysmorphic disorder, the diagnostic
13 criteria is the -- is the patient who
14 presents with evidence of a psychological
15 disturbance. In review of their history
16 and physical examination, you may see
17 evidence of a history of substance abuse,
18 maybe evidence of some self-harm,
19 evidence of social isolation in their
20 intake forms, that sort of thing. That
21 would raise the concern.

22 The second would be the person
23 who attaches tremendous potential benefit

1 of, psychologically, the -- the quality
2 of the -- sort of a transformative power
3 of cosmetic surgery.

4 And then the third criteria
5 would be that they -- they see something
6 that you don't see. They see a defect
7 that you don't see. And that's probably
8 the key diagnostic criteria. For
9 example, a man who presents seeking a
10 modification to his nose who has evidence
11 of living a life of social isolation who
12 is adamant that by changing his -- the
13 appearance of his nose, he will -- he
14 will have a much better life. And
15 hearing that, of course, the alarm bells
16 go off and then examining the patient and
17 seeing that there's no objectively
18 definable deformity, only a normal
19 variation that one would expect to see on
20 a man's face.

21 Those are all red flags. And --
22 and based upon that, it is -- it
23 is definitely the -- has been

1 historically the recommendation of the
2 likes of Dr. Mark Gorney and other
3 leaders in the American Society of
4 Plastic Surgery to not offer surgery, but
5 rather to offer referral for
6 psychiatric/psychological support and
7 evaluation.

8 Q. These diag- -- these diagnostic
9 criteria that you mentioned, where do
10 they come from?

11 A. They -- I think you can find
12 much of that in the DSM book, if -- if --
13 if that's the route you want to go. You
14 find it in the literature. There are --
15 there are references in the scientific
16 literature about it dating back to I
17 think the 1920s. I included some of
18 those, I think, in my discussion, if not
19 on this one, in the Arkansas case.

20 But -- but there have been
21 papers published through the years that
22 describe the condition and make
23 recommendations about care, and again,

1 going all the way back even to textbooks
2 in plastic surgery and -- and of course,
3 the residency training that speaks about
4 that as well.

5 Q. So for diagnosing someone with
6 body dysmorphic disorder, you would rely
7 on the DSM-5; right?

8 A. I wouldn't rely on it, no. No.
9 I would rely on my -- my clinical
10 experience more than anything else there.

11 Q. Well, you just rattled off three
12 or four guidelines that I think I heard
13 you say come from the DSM-5; right?

14 MR. KNEPPER: Objection, form.

15 A. Well, they're -- they don't come
16 from the DSM-5 but are described in the
17 DSM-5, yeah.

18 Q. So when I asked you --

19 A. And 4 -- actually, DSM-4 has a
20 clearer description, I think, than DSM-5.

21 Q. So when I asked you what
22 criteria you would use to diagnose
23 someone with body dysmorphic disorder,

the source you went to was the DSM;
right?

A. No. The source I went to was my training and the -- and the papers that relate to it. I think it's just been subsequently characterized in the DSM. And it's a ready -- it's a volume that's readily accessible to people. The language is readily accessible, so people who are seeking information about that, they can go there for it or they can go to the articles, if they like. Yes.

Q. Outside of whatever training you had on diagnosing someone with body dysmorphic disorder, you do not have specialist training or expertise in diagnosing other mental health conditions; fair?

19 MR. KNEPPER: Objection, form.

20 A. Let's see. Well, there's -- I
21 guess there are subcategories of -- of
22 body dysmorphic disorder, like
23 recognizing the anorexic patient, of

1 course, who presents for body
2 modification. That -- that's a fairly
3 readily and obvious one.

4 But no, I'm not a -- I'm not
5 formally trained in psychiatry or
6 psychology.

7 Q. You do not have -- you do not
8 hold yourself out as an expert in
9 diagnosing mental health conditions
10 outside, potentially, of body dysmorphic
11 disorder; right?

12 A. Correct.

13 Q. You do not have specialist
14 training or expertise in treating mental
15 health conditions; right?

16 A. No.

17 Q. You would refer that person to a
18 qualified mental health professional;
19 right?

20 A. I would. I would.

21 Q. Because you yourself are not a
22 qualified mental health professional;
23 correct?

1 A. Correct.

2 Q. All right. You've also
3 published an op-ed in May of this year
4 supporting this Alabama ban; correct?

5 A. Yes.

6 Q. And you said that Alabama
7 legislators should enact this ban because
8 they have a duty to protect the
9 vulnerable population of gender-confused
10 children. Does that sound familiar?

11 A. Yes.

12 Q. So again, earlier you said you
13 had a preference for professional
14 societies dealing with this, but you're
15 out there publishing op-eds calling on
16 state legislatures to pass these bans;
17 right?

18 MR. KNEPPER: Objection, form.

19 A. Right. Yes, sir.

20 Q. All right. How about Texas?
21 Tell me what work you've done supporting
22 this kind of a ban in Texas?

23 A. It's been similar. I've been in

1 communication with -- I can't remember if
2 they're on the legislative side or on the
3 justice side. I don't remember exactly
4 where they fit into the -- the government
5 of Texas, but I've corresponded with them
6 and offered them information and advice.

7 Q. Was it similar information to
8 what we've seen in that Utah packet?

9 A. I'm sorry, sir?

10 Q. Was it information similar to
11 what we've seen in that Utah legislation
12 packet?

13 MR. KNEPPER: Objection, form.

14 A. Right. The substance -- the
15 substance of the issue at hand is the
16 same wherever you find it. It's this
17 contest between those who -- who promote
18 gender-affirming care versus those who
19 promote, in the case of children, for
20 example, watchful waiting and
21 psychological support and cognitive
22 behavioral therapy and those things, yes.
23 It's the same battle wherever you find it

1 because it's the same problem, the same
2 science, the same language. All of it's
3 the same.

4 Q. So earlier, we saw that in
5 addition to you, Dr. Hruz and Dr. Levine
6 and Dr. McHugh were also involved with
7 those Utah legislative efforts; right?

8 MR. KNEPPER: Objection, form.

9 A. I -- I don't know their
10 involvement in -- in Texas. I'm -- I'm
11 not aware.

12 Q. Yeah. Do you know whether any
13 of them have been involved with any of
14 these efforts in any other state?

15 A. I don't. I don't know.

16 Q. Okay. Fair to say that you have
17 some strong personal opinions on whether
18 doctors should be providing
19 gender-affirming treatment to minors?

20 MR. KNEPPER: Objection to form.

21 A. Very fair to -- very fair to
22 say, yes.

23 MR. TISHYEVICH: Let's go off

the record.

2 THE VIDEOGRAPHER: This is the
3 end of Media Unit 1. We are off the
4 record at 9:33 a.m.

5 (Break taken.)

9 Q. (By Mr. Tishyevich) Doctor,
10 you're familiar with an organization
11 called Alliance Defending Freedom, ADF;
12 right?

13 A. Yes.

14 Q. How are you familiar with the
15 ADF?

16 A. I was invited down there for a
17 conference on the subject of transgender.
18 I was an invited presenter, I should say.
19 They asked me to come and speak from a
20 plastic surgeon's perspective on how I
21 view the current state of transgender
22 medicine and surgery.

O. Those were -- those were the

1 meetings in Arizona? Is that right?

2 MR. KNEPPER: Objection.

3 A. Yes.

4 Q. Who invited you?

5 A. I don't remember who the
6 particular name was. I -- I don't recall
7 who the -- the particular person, the one
8 that sent me the invitation.

9 Q. Was it --

10 A. It may have been -- it may have
11 been Gary McCaleb, I want to say. I'm
12 not positive about that, though.

13 Q. You -- you anticipated my
14 question.

15 A. Okay.

16 Q. To your knowledge, what's the
17 view that the FDA takes on providing
18 healthcare treatment to patients with
19 gender dysphoria?

20 A. The position of the FDA?

21 Q. The ADF.

22 A. Oh, the ADF. They -- let's see.

23 So, the sense I get is that the ADF takes

1 a -- the opinion that the present state
2 of transgender medicine and surgery is
3 not in the interest of the patients or
4 the families.

5 Q. The ADF has moral objections to
6 doctors performing this kind of surgery
7 and treatment; right?

8 MR. KNEPPER: Objection, form,
9 scope.

10 A. I would -- I would characterize
11 the ADF's position as more than just a
12 moral objection. It's both moral and
13 objective scientific objections.

14 So the -- the -- the sense I got
15 from that conference was that most of the
16 invited speakers came to speak about --
17 for example, Dr. Hruz was there, and he
18 spoke about endocrinology and the
19 endocrinol- -- endocrinologic basis for
20 sex/gender. And he spoke about the
21 effects of -- the endocrinological
22 effects, the objective changes that are
23 caused by, for example, puberty-blocking

1 cross-sex hormones.

2 I was -- there was also another
3 speaker there, I think, on the subject
4 of -- from the family medicine
5 perspective, the overall effects on the
6 health of the child, developmental
7 issues. There was a presenter on the
8 objective psychological issues.

9 And then, I presented on the
10 realities of the surgery. They wanted me
11 to speak about the technical details of
12 transgender surgery, kind of the
13 evolution of the process of transitioning
14 surgery, and the -- and to give them a
15 summary of the state of the science on
16 it.

17 So I would characterize the ADF
18 as interested in both the moral -- the
19 moral issues and the objective, and they
20 impinge upon one another. Clearly, to do
21 something that is not in the -- in the
22 objective benefit of the patient is a
23 moral problem.

1 Did I answer your question?

2 Q. That's helpful, yeah.

3 The ADF is not a professional
4 scientific organization; right?

5 A. Not to my knowledge, no.

6 MR. KNEPPER: Objection to form,
7 scope.

8 Q. They're a legal organization;
9 right?

10 A. Yes. That's my understanding.

11 Q. ADF is engaged with bringing
12 lawsuits that do things like challenge
13 schools' rights to -- to have transgender
14 persons on their teams; right?

15 MR. KNEPPER: Objection, form,
16 scope.

17 A. I don't know the scope, the full
18 scope of their efforts, but yeah, they're
19 one of I guess several legal
20 organizations that are -- that are
21 approaching these matters, as are you,
22 for example.

23 Q. All right. Let's talk about

1 these meetings in more detail. So, how
2 many -- strike that.

3 You've been to two meetings
4 organized by ADF?

5 A. That's my recoll- -- yeah, two
6 meetings. I think that's right.

7 Q. All right. Let's start with the
8 first one. This was in 2017?

9 A. That sounds about right, yeah.

10 Q. What --

11 A. I think it was 2017, yeah.

12 Q. What month roughly?

13 A. I don't remember now.

14 Q. Do you know how they came to
15 invite you to that first meeting?

16 A. I do not.

17 Q. Before that meeting, you had not
18 published anything about gender
19 dysphoria, had you?

20 A. No.

21 Q. Before that meeting, you had not
22 published anything about the risks of use
23 of hormone blockers in minors; right?

1 A. No. I've given -- I gave some
2 -- some -- I think they may have heard of
3 me not through publications, but through
4 public speaking.

5 Q. How long have you been doing
6 public speaking on the issues related to
7 gender dysphoria?

8 A. Since 2014.

9 Q. Let's start with the first
10 meeting. So, Dr. Hruz was also present
11 at that meeting?

12 A. Yes.

13 Q. Was Dr. Levine present at that
14 meeting?

15 A. I don't think I've ever met Dr.
16 Levine, so I don't -- he couldn't have
17 been there because I would have
18 remembered meeting him, and I don't
19 remember ever having met him.

20 Q. How about Dr. McHugh?

21 A. No. I would have remembered
22 him. He's a very famous person.

23 Q. How many people were present at

1 this first meeting?

2 A. Perhaps ten. I'm not certain.

3 Q. Outside of you and Dr. Hruz, who
4 else do you remember being at that first
5 meeting?

6 A. I remember meeting a Dr. Andre
7 Van Mol. I believe he was at that
8 meeting. There was a pediatric
9 endocrinologist there by the name of
10 Quentin Van Meter. I think he was there.

11 There was a -- there was an
12 expert in scientific data and scientific
13 data analysis, medical record data
14 analysis from UC-San Francisco. I don't
15 believe he was a physician. I think he
16 was a -- had a doctorate in science. And
17 he was a -- he was actually a
18 detransitioner. So he was giving not
19 only his knowledge of the medical
20 literature, he was just an incredible
21 resource and reference for medical
22 literature. You could just about ask him
23 anything. But he was also there, I

1 think, to speak from a personal
2 perspective as well, being a
3 detransitioner.

4 There was another detransitioner
5 there who I don't remember their name,
6 but they were there to speak. I think
7 they were also an educator as well. I'm
8 not positive about that.

9 So it's kind of vague for me,
10 but I -- but definitely Paul Hruz stands
11 out because we had a very good
12 conversation there.

13 Q. What was the format? Were there
14 presentations, a round table discussion?
15 How did the conversations go?

16 A. There was some introductory
17 remarks, and then -- and then each --
18 each sort of specialist gave a
19 presentation. I think I gave an
20 hour-long presentation. And there were
21 others like mine on those other subjects
22 we talked about.

23 Q. Did you use slides as part of

1 that presentation?

2 A. I usually do, yes, although I
3 don't know what I've done with that slide
4 deck. I don't keep them very long. They
5 sort of morph all the time.

6 Q. Do you think you might have an
7 electronic copy of that slide deck
8 somewhere?

9 A. I don't.

10 Q. At a very high level, what was
11 the -- what were you trying to convey
12 through your presentation to that group?
13 Let me ask it a different way. Were --
14 was your presentation broadly similar to
15 the opinions that you're offering in this
16 case and in the Brandt case?

17 MR. KNEPPER: Objection, form.

18 A. Well, by the -- by "broadly
19 similar," do you mean the subject matter
20 or the nature of my opinion or the
21 evidence used to support my opinion?

22 Q. All right. Give me a high-level
23 summary of what your presentation was at

1 that first meeting.

2 A. It was a --

3 MR. KNEPPER: Objection, form,
4 scope.

5 A. -- a summary, a summary of the
6 present state of transgender medicine and
7 surgery, a review of the scientific
8 literature used to support the treatments
9 that are being offered, a review of the
10 long-term outcomes of treatment that are
11 being offered, with particular attention
12 to the European literature, which is more
13 reliable. I sort of -- I compared the
14 American literature to the European
15 literature because that's one of the
16 great problems we're having in this
17 issue. And it was already evident in
18 2017 that there was a great disparity
19 between the American literature and the
20 European literature in terms of the
21 quality of the scientific evidence that's
22 being used to support the interventions.

23 So that was -- really at the

1 heart of the presentation was what's the
2 state of the science and where is the
3 reliable science coming from and what is
4 it -- what is it showing us, so. But
5 they also -- the audience wanted to have
6 an understanding of what these plastic
7 surgery interventions were. So there was
8 an extensive discussion of the
9 particulars of the surgeries, the details
10 about the surgeries, the typical outcomes
11 of the surgeries, so.

12 Q. I want to -- strike that.

13 One of the topics of discussion
14 at that meeting was about the need to
15 have expert witnesses for litigation;
16 right?

17 MR. KNEPPER: Objection, form,
18 scope.

19 A. I remember -- I remember a
20 fairly long discussion about the poverty
21 of people who are willing to testify
22 because of the risk that they take in
23 testifying. That was a -- that was a

1 fairly long discussion. And the
2 difficulty that that -- that people have
3 in finding expert witnesses because of
4 the risks they place themselves in, in
5 testifying.

6 Q. And people at that meeting were
7 asked whether they would be willing to
8 participate as expert witnesses; right?

9 A. Yes.

10 Q. Before that meeting, you had
11 never testified as an expert witness?

12 A. Before this moment, I never
13 testified as an expert witness.

14 Q. Who made the introductory
15 remarks at the beginning of this meeting?

16 MR. KNEPPER: Objection, form,
17 scope.

18 A. I'm trying to remember. It was
19 a -- it was an attorney whose first name
20 is Jeff, and I'm trying to remember what
21 his last name was. But he seemed to be
22 the -- the -- kind of the emcee, if you
23 will. Yeah, Jeff. I'll see if, in the

1 course of our conversation today, the
2 name will pop in. This is the difficulty
3 I have with remembering names. They'll
4 just pop in at a moment's notice.

5 But it was -- yeah, it was an
6 attorney who gave the overall scope of
7 why -- why we were there, to discuss this
8 issue, to see what -- what the -- what
9 the science is showing to see where --
10 what the -- the moral aspects of good
11 science versus bad science and issues
12 like that, yeah.

13 Q. Aside from you and Dr. Hruz, do
14 you recall anyone else expressing an
15 interest at that conference about serving
16 as an expert witness?

17 MR. KNEPPER: Objection, form,
18 scope.

19 A. You mean someone expressing just
20 generally about having expert witnesses?

21 Q. No. Other participants saying,
22 "I might consider being an expert witness
23 in one of these cases."

1 A. I don't recall. I don't, no.

2 Q. Okay. All right. So then there
3 was a second meeting also in Arizona;
4 right?

5 A. Right.

6 Q. And that was also in 2017?

7 A. I don't remember the date of
8 that as well -- either, no.

9 Q. What was the purpose of that
10 second meeting?

11 A. I think it was similar, although
12 it may have been a little bit more
13 refined. There was not as much
14 discussion of the really foundational
15 science as more a review, I think, of --
16 you know, I -- I guess it was similar in
17 terms of format. I think there were more
18 -- more people there who were speaking
19 from personal experience.

20 So I think the most important
21 thing I recall from that meeting was that
22 -- that there was a mother -- actually, a
23 couple of family members of persons who

1 experienced cross-sex self-identification
2 who have gone through various -- various
3 phases of transitioning. And they were
4 giving sort of a personal experience,
5 trying to describe to us what they went
6 through as a family, what they went
7 through with their children. And that's
8 what -- so that was the difference
9 between the first and the second meeting.
10 I think it was more of a personal thing.
11 It had the science as well, but I think
12 it had more of a personal side to it as
13 well.

14 Q. How many people do you think
15 attended -- attended that second meeting?

16 A. I'm trying to think how full the
17 room was. I think it was probably
18 comparable maybe, a dozen perhaps. I'm
19 not sure.

20 Q. Who do you remember being there
21 by name?

22 A. I think that may have been when
23 I met Dr. Cretella. I can't remember if

1 I met her at the first meeting or the
2 second meeting.

3 Oh, also at that second meeting,
4 there was a plastic surgeon. I can't
5 remember his last name. I was -- I
6 remember being very encouraged to meet
7 another plastic surgeon who saw this as
8 an issue. And I do remember that he had
9 been the chairman -- this speaks to the
10 issue of fear about testifying. He had
11 been the chairman of a major plastic
12 surgery department in a large Midwest
13 university, had built that program for
14 many years, had run one of the most
15 successful residency training programs.
16 And he had been fired because he had
17 objections to the transgender services
18 that the hospital administration -- or
19 the university administration wanted to
20 introduce. And I thought it was a very
21 heartbreaking story to see that a man had
22 lost his entire career over his
23 professional opinion. I don't remember

1 his last name, but I do know that I met
2 him at that second meeting.

3 Q. Do you remember his first name?

4 A. I don't.

5 Q. Do you remember which center he
6 was affiliated with?

7 A. I believe he was from the Ohio
8 State University. But I haven't seen or
9 heard from him since. He has just
10 disappeared. I tried to reach out to
11 him, I recall, because, again, there's
12 not a lot of plastic surgeons who are
13 willing to speak on this matter. And --
14 but I haven't heard from him since.

15 Q. Did participants at the second
16 meeting make presenta- -- make
17 presentations as well?

18 MR. KNEPPER: Objection, form,
19 scope.

20 A. I -- I don't -- yeah, I think it
21 was more limited presentations, briefer,
22 sort of reviews sort of thing. But it
23 wasn't -- it didn't have the formality of

1 the first meeting, as I recall. Again,
2 it's -- it's a little bit murky four
3 years on.

4 Q. Yeah. I'm just asking for your
5 best recollection. That's fine.

6 A. Sure. Okay.

7 Q. Do you remember giving a
8 presentation at that second meeting?

9 A. I believe I did.

10 Q. How long do you think that
11 meeting lasted, roughly?

12 MR. KNEPPER: Objection, form,
13 scope.

14 A. Well, I remember it -- we went
15 through a full morning, a light lunch,
16 and perhaps into the very early
17 afternoon.

18 Q. And you mentioned that there was
19 some personal testimony from parents,
20 families. What portion of the meeting
21 was that, roughly?

22 A. What -- what portion?

23 MR. KNEPPER: Objection, form,

1 scope.

2 Q. What portion, yes.

3 A. I would be guessing that perhaps
4 a third of the meeting was -- was that.

5 Q. Okay. After these meetings in
6 2017, have you continued to stay in touch
7 with the ADF?

8 MR. KNEPPER: Objection, form,
9 scope.

10 A. I think perhaps, you know, one
11 or two e-mail exchanges, but nothing --
12 nothing substantive. I haven't really
13 heard anything from them. I think I got
14 a -- no. Well, I can't -- I can't recall
15 anything other than maybe a thank-you
16 e-mail or hope you're doing well kind of
17 thing, but nothing substantive, no.

18 Q. How did you come to get involved
19 with being an expert in this case?

20 A. I was contacted by Mr. Knepper.

21 Q. Okay.

22 A. Actually, I was contacted by his
23 staff. He didn't call me himself, but

1 his -- someone on his staff called me and
2 asked --

3 Q. I understand.

4 A. -- if I would be available.

5 Yeah.

6 Q. How did you come to get involved
7 with the Brandt case in Arkansas?

8 MR. KNEPPER: Objection, form,
9 scope.

10 A. I think it may have been
11 similar. I don't recall the particulars,
12 but I -- someone on -- on the legal
13 counsel side contacted me. I don't
14 remember who it was.

15 Q. Okay. Let me shift gears a bit.
16 You know what the American Society of
17 Plastic Surgeons is; right?

18 A. Of course.

19 Q. Are you a current member?

20 A. No. I -- I let my membership
21 lapse years ago, yeah.

22 Q. When --

23 A. About two years ago, I would

1 say. Maybe two years ago, yeah.

2 Q. Why did you decide to let your
3 membership lapse?

4 A. Well, in order to be a member of
5 the American Society of Plastic Surgeons,
6 you have to be board-certified. And so
7 since I declined continuing board
8 certification for the reasons I explained
9 to you, then my membership -- you know,
10 over time, when my subscriptions and
11 membership fees lapsed, so did my
12 membership. And I think that would have
13 been in 2019.

14 Q. I understand.

15 A. Yeah.

16 Q. Is it -- is an active board
17 certification in plastic surgery a
18 prerequisite to being in the American
19 Society of Plastic Surgeons?

20 A. I seem to remember that when I
21 -- back in the '90s after my residency,
22 there's a -- there's a membership for --
23 for board-eligible. It's not the full

1 membership, but then when you get
2 board-certified, then you get full
3 membership and the rights to use the logo
4 and all that sort of stuff, so. Yeah, as
5 I recall. It's been a long time since I
6 read the bylaws. That would have been
7 back in '95, I think, that I read those
8 things.

9 Q. Yeah. When did you first join
10 the ASPS?

11 A. I think I joined as a student
12 member when I was in my residency. I
13 want to say it was probably like '92 or
14 '93, somewhere in there.

15 Q. So you were in the ASPS roughly
16 '92 --

17 A. I think, yeah.

18 Q. -- to 2017?

19 A. I think, yeah. As I recall --
20 again, it's a little bit murky, but as I
21 recall, there's sort of a provisional
22 membership for residents in training.
23 You sort of get a discounted rate on all

1 of the expensive things, and the -- and
2 access to the White Journal, as it's
3 called. And then -- and then I -- as I
4 recall, you don't get the full membership
5 until you've been board-certified, which
6 happened for me, as you know, in '97.

7 Q. Okay. But you were part of the
8 ASPS for a long time; right?

9 A. Yes. Going to meetings.

10 Q. You consider the ASPS to be a
11 reputable organization; right?

12 MR. KNEPPER: Objection, form.

13 A. Yeah. Well, for the most part,
14 yeah. Certainly, the members, virtually
15 most of the members I've ever known are
16 reputable. And there are some things
17 that the ASPS has done through the years
18 that -- that I've had difficulty with
19 and -- but they're certainly the
20 organization in American plastic surgery.

21 Q. Yeah. I think one statistic I
22 heard is 93 or so percent of all plastic
23 surgeons are part of the ASPS.

1 A. Yeah.

2 Q. Right?

3 A. That -- that number wouldn't
4 surprise -- I would have thought even
5 higher, actually, but yeah.

6 Q. Do you think the ASPS would
7 encourage its members to perform
8 surgeries that are not medically
9 necessary?

10 MR. KNEPPER: Objection, form.

11 A. Well, the -- as a -- as an
12 organization, they don't encourage
13 particular surgeries, but they may
14 support them with their scientific
15 presentations, their conferences, and
16 that sort of thing.

17 For example, three or four years
18 ago, I went to a meeting of the
19 California Society of Plastic Surgery,
20 which is -- I think it has sort of a
21 subsidiary relationship with the ASPS.
22 And at that conference, among other
23 things -- I went there because that's one

1 of the -- the areas of the country where
2 I trained and I had hoped to see some
3 friends there. But -- but for example,
4 in that conference I went to a lot of
5 great presentations, but the last day was
6 devoted almost entirely to transgender
7 surgery.

8 And so if you're asking me do I
9 -- how do I feel about that, well, I have
10 great difficulty with a professional
11 organization that would support or
12 promote those sorts of interventions
13 knowing what I know about the scientific
14 underpinnings of those medical and
15 surgical procedures. And I had many
16 conversations at that conference on the
17 subject with persons who were providing
18 the services, and I didn't find their
19 answers particularly satisfactory. So
20 that would be an example.

21 I can't give you carte blanche
22 that everything that the Society says and
23 does is to my liking. I would say

1 probably most of what they say and do is
2 very much to my liking. But on this
3 matter, I have -- I have a great
4 difficulty. And it's one of the reasons
5 that I -- I -- yeah.

6 Q. It's one of -- one of the
7 reasons that you what?

8 A. That I -- that I don't have a
9 lot of heartache about stepping away from
10 the ASPS.

11 Q. Do you think the AS- -- ASPS
12 advocates in favor of surgical procedures
13 that are not medically necessary?

14 A. I think that would be probably
15 an overreaching statement. I wouldn't
16 say that. I would say that perhaps
17 they're mute on some of the -- some of
18 the procedures that their members
19 perform, and they certainly have their
20 eyes and ears open for new things. And
21 so when members come forward to make
22 presentations about particular new
23 therapies and new approaches, as they

1 should, the ASPS is open to those things.
2 So for many years, transgender surgery
3 has been in that category.

4 I remember when I was a -- even
5 when I was a general surgeon and I was
6 looking for residency programs to train
7 in, I was considering UVA. And I saw
8 that -- that Milton Edgerton, one of the
9 great names in plastic surgery was at UVA
10 doing transgender surgery, both at UVA
11 and at Johns Hopkins. And I remember
12 thinking, well, I'm -- I really need --
13 it struck me as an unusual operation, and
14 I -- I started doing some research into
15 it.

16 And I remember starting to think
17 about the issue of transgender surgery
18 back in the -- what would have been 1991,
19 1990, 1991. And -- and through the
20 years, the ASPS has made room for that
21 intervention, those therapies, in their
22 conferences, in their dialogues, in their
23 publications. And I've reviewed all that

1 stuff as it has come along. And I think
2 now being twenty, nearly thirty years on
3 since I first started looking at it and
4 they're still just sort of at that stage
5 of -- of putting it out there, although
6 now they're offering more extensive
7 training conferences on how to do those
8 procedures, and they're now encouraging
9 that it be included in residency
10 programs, and so -- yeah.

11 Q. Do you know what position the
12 ASPS takes on whether gender-affirming
13 surgery is medically necessary?

14 A. I think that position has
15 changed, and now they're -- they're
16 speaking positively about it.

17 Q. Yeah. Your own professional
18 organization, or at least your former
19 organization, takes the position that
20 gender-affirming surgery is medically
21 necessary; right?

22 MR. KNEPPER: Objection, form.

23 A. Yeah. As I -- as I said before,

1 this is one of the reasons why I don't
2 have a lot of heartache about having
3 withdrawn my membership. Yeah.

4 Q. Now let me introduce another
5 exhibit. Let me know when you have it,
6 Doctor.

7 (Exhibit 7 was marked for identification
8 and is attached.)

9 A. Okay. Okay. I've got it.

10 Q. The top of the page says,
11 "American Society of Plastic Surgeons."
12 Right?

13 A. Yes.

14 Q. You see this document is dated
15 February 25, 2021; right?

16 A. Yes.

17 Q. This is after all the studies
18 that you cite in your report; right?

19 A. Where does that say that? I'm
20 sorry, you're at a particular paragraph?

21 Q. No. The date of this --

22 A. Oh, I see. Oh, the date is
23 after this --

1 Q. Yeah.

2 A. Yes. Well, February 25th, yes,
3 2021.

4 Q. Yeah. This is -- this is dated
5 after all of the studies that you cite in
6 your report; correct?

7 A. I don't -- yeah, I don't
8 remember off the top of my head any
9 studies that were dated after. There may
10 have been an April study in there, but
11 okay.

12 Q. The first sentence says, "Policy
13 around transgender care has recently
14 gained considerable attention amid a
15 growing trend of legislation carrying
16 serious professional, financial or
17 criminal penalties for the provision of
18 gender affirmation care." You see that?

19 A. I do.

20 Q. Now, this reference to a growing
21 trend of legislation, that's talking
22 about legislation like the Arkansas ban
23 and the Utah ban and the Alabama ban that

1 we talked about earlier; right?

2 A. Right.

3 MR. KNEPPER: Objection, form.

4 Q. Go to page 2. Look at the
5 second paragraph. It says that "Less
6 than three months into 2021, 11 pieces of
7 legislation attempting to criminalize
8 gender affirmation therapies have been
9 introduced in 10 states." See that?

10 A. I do.

11 Q. And then there's a list of
12 states; right?

13 A. Yes.

14 Q. So we talked about Utah and
15 Alabama and Texas before. Looking at
16 this list, does that refresh your
17 recollection whether you've worked on
18 these kind of legislative efforts in any
19 other states?

20 A. I think -- I think, yeah, my
21 answer has not changed. I think I've
22 only been involved in Alabama, Texas, and
23 Utah. I don't remember anything from

1 Oklahoma, New Hampshire, Montana, or
2 Missouri or Mississippi. I don't recall
3 any other states in that list, no.

4 Q. Okay. All right. Now let's
5 look at what position the ASPS takes on
6 whether gender-affirming treatment is
7 medically necessary. Go to page 3. The
8 first sentence says, "ASPS firmly
9 believes that plastic surgery services
10 can help gender dysphoria patients align
11 their bodies with whom they know
12 themselves to be and improve their
13 overall mental health and well-being."
14 Do you see that?

15 A. I do.

16 Q. The ASPS, your own professional
17 organization, does not agree with your
18 opinions that gender-affirming surgery is
19 medically inappropriate; right?

20 MR. KNEPPER: Objection, form.

21 A. Let me just read that. Give me
22 just a moment to look at that. Okay.

23 Yeah. This is a very --

1 language used by the other professional
2 organizations, and essentially, the
3 language takes the position that surgical
4 intervention for a subjective problem is
5 medically indicated. And that's the
6 difficulty that I'm having here, is that
7 in this document the ASPS does not --
8 does not provide medical scientific
9 support. They essentially admit that the
10 surgery is for help with a psychological
11 problem of perception on the part of the
12 patient. So essentially what -- what the
13 ASPS firmly believes in is the use of
14 surgery to manage a psychological
15 problem. And -- and this is -- this is
16 consonant with the -- with the -- the
17 consensus opinions that were offered by
18 the other professional organizations that
19 you listed earlier.

20 Q. The AS- -- ASPS does not agree
21 with your opinions that gender-affirming
22 surgery is experimental; correct?

23 MR. KNEPPER: Objection, form.

1 A. They don't -- let's see, do they
2 say anything about experimental in here?
3 No, they don't. So yeah, I would agree.

4 Q. Do you agree? Yeah.

5 A. I would agree, yeah, sure.

6 Q. Look at the last sentence. It
7 says, "ASPS will continue its efforts to
8 advocate across state legislatures for
9 full access to medically necessary
10 transition care." Do you see that?

11 A. Yeah. I don't find that
12 statement at all surprising. No.

13 Q. Yeah.

14 A. I do see that, yeah. Not
15 surprising. This is legislative --

16 Q. The ASPS --

17 A. -- legislative advocacy by the
18 ASPS.

19 Q. The ASPS considers transition
20 care to be medically necessary; right?

21 MR. KNEPPER: Objection, form.

22 A. Again, that returns -- returns
23 to that -- that inherent and

1 contradictory statement of medical
2 necessity for a subjective condition.
3 And the statement is consistent with what
4 -- yeah. Exactly, yeah.

5 Q. It's fair to say that the
6 opinions that you and Dr. Hruz and Dr.
7 Levine are offering in this case are very
8 different than the position that the ASPS
9 has adopted on whether gender-affirming
10 surgery is medically necessary; right?

11 MR. KNEPPER: Objection, form.

12 A. Absolutely correct.

13 Q. In fact, let me show you how
14 strongly the ASPS feels about this issue.
15 Let me introduce another exhibit. Okay.
16 Let me know when you -- when you receive
17 it.

18 MR. KNEPPER: Dmitriy, I -- I
19 will tell you, it seems to be moving more
20 slowly than normal. I don't know if
21 you're seeing the same thing on your end.

22 MR. TISHYEVICH: I am.

23 A. So yeah, I have this document.

1 Again from the ASPS? Is that the one?

2 February 25th?

3 Q. No. It should be -- it's a
4 one-page document. I think it just says
5 ASPS in your folder.

6 A. Exhibit 7?

7 MR. TISHYEVICH: Let me -- let's
8 go off the record for a minute.

9 MR. KNEPPER: Sure.

10 THE VIDEOGRAPHER: We are off
11 the record at 10:19 a.m.

12 (Break taken.)

13 THE VIDEOGRAPHER: We are back
14 on the record at 10:21 a.m.

15 Q. (By Mr. Tishyevich) All right.
16 Doctor, before the break, we were talking
17 about the ASPS and the position they take
18 on the medical necessity of
19 gender-affirming surgery. You recall
20 that?

21 A. Yes.

22 Q. All right. This is a document
23 from the ASPS titled "2021 State Policy

1 Priorities." Do you see that?
2 (Exhibit 8 was marked for identification
3 and is attached.)

4 A. Yes.

5 Q. Last sentence of the first
6 paragraph says, "To ensure that our
7 health care system is effective and
8 efficient, ASPS will focus its state
9 advocacy efforts on," and then there's a
10 list. Do you see that?

11 A. Yes.

12 Q. And there's three sections:
13 "Core Priorities," "High Priorities," and
14 "Other Priorities." You see that?

15 A. Yes.

16 Q. Go to the "High Priorities"
17 section.

18 A. Okay.

19 Q. The last bullet says, "Opposing
20 attempts to criminalize gender
21 confirmation." Do you see that?

22 A. I do.

23 Q. And you understand what this

1 bullet means; right?

2 A. I do.

3 MR. KNEPPER: Objection to form.

4 Q. One of the ASPS's high
5 priorities for this year is to oppose
6 legislation like the Arkansas ban and the
7 Utah ban and the Alabama ban that you are
8 supporting; right?

9 A. Apparently so, yes.

10 MR. KNEPPER: Objection, form,
11 scope.

12 Q. The sense that I got from
13 reading your report, Doctor, is that it's
14 supposedly generally accepted that
15 gender-affirming surgical treatment is
16 experimental and should not be performed
17 on anyone; right? That's what you think?

18 MR. KNEPPER: Objection, scope,
19 form.

20 A. Right. My opinion -- my opinion
21 in that matter is based on the -- on the
22 world literature rather than advocacy
23 statements by a professional

1 organization. That's right.

2 Q. You are suggesting, in fact,
3 that doctors who do these surgeries
4 should be investigated for unethical
5 behavior and potential misconduct; right?

6 MR. KNEPPER: Objection, form.

7 A. I -- yes, I do.

8 Q. And you do not think it's
9 relevant to mention that your own
10 professional society takes a view that is
11 contrary to the opinions that you're
12 offering in this case; right?

13 A. I'm not sure I understood your
14 question, sir.

15 Q. Yeah. When you talk about how
16 these doctors should be investigated for
17 misconduct, you don't think it's relevant
18 that your own professional society takes
19 a completely contrary view?

20 MR. KNEPPER: Objection, form.

21 A. Well, I think I would -- I would
22 characterize my concern and -- and
23 possibly recommendation of investigation,

1 I was discussing, I think, consent
2 procedures and getting informed consent.
3 I don't think -- yeah, so -- so I think
4 the object- -- the concerns I raised had
5 to do with the off-label use of drugs in
6 irreversible treatments, the -- the
7 problem of obtaining consent from
8 emotionally compromised people who are
9 threatening suicide. Those were the
10 issues that I raised in terms of, you
11 know, investigation kind of things, or
12 examination would be a better term,
13 examination of -- of how a
14 physician/surgeon conducts their
15 practice, so.

16 Q. Go -- go back to your report.

17 A. Okay.

18 Q. Go to page 15. You with me?

19 A. Yes, sir.

20 Q. Look at the second sentence in
21 the bottom paragraph. You say, "Basing
22 life changing surgeries that damage and
23 destroy the natural functions of

1 perfectly healthy organs on nothing more
2 than the unverified self-reports
3 (conversations) of often disturbed
4 patients as part of untested, unproven,
5 experimental 'treatments' that are
6 'supported' by a methodo- --
7 "methodologically defective research base
8 when competent reviews have called such
9 research 'low quality' evidence and noted
10 the 'lack of any randomized clinical
11 trials' -- should be properly
12 investigated as unethical, misconduct and
13 an abuse of a vulnerable patient
14 population."

15 Right? That's your opinion?

16 A. Yes, sir. And I stand by that.

17 Q. You know that today there's
18 thousands of plastic surgeons that are
19 performing these surgeries; right?

20 MR. KNEPPER: Objection, form,
21 scope.

22 A. I don't know the number of
23 plastic surgeons who do these surgeries.

1 Q. Hundreds?

2 A. I'm -- I'm sure the number is
3 large. I don't know what the number is.

4 Yes.

5 Q. And you think all of those
6 doctors are out there committing
7 misconduct? Is that really what you
8 think?

9 A. Well, I think that -- that their
10 knowledge might affect their
11 decision-making. So if somebody is going
12 through a residency training program that
13 -- that is teaching these things and they
14 grow up in that world -- let me give you
15 an example.

16 When I was a surgeon in training
17 in general surgery, the -- the most
18 coveted surgical experience would be, as
19 a chief resident, to do ulcer surgery.
20 At the time, we thought that ulcers were
21 caused by neurologic problems affecting
22 the stomach. And so some of the most
23 complex abdominal surgeries were ulcer

1 surgeries, and some of the greatest names
2 in general surgery were given to those
3 operations. Subsequent to my residency
4 training, perhaps five years later, it
5 was found to be a medical condition
6 treatable with antibiotics and antacids.
7 Nobody does ulcer surgery any longer.

8 I would put -- I would put
9 transgender surgery in the same category.
10 Well-meaning persons who are interested
11 in the care of people who are suffering,
12 in this case, transgender persons who are
13 suffering, well-meaning physicians and
14 surgeons are offering them the best care
15 that they've learned in their training.
16 But I -- I would expect that when the
17 science shows that to be not the case,
18 that those same doctors will abandon it.
19 And I think we're at the same stage now.
20 We're at an inflection point in plastic
21 surgery where in the last three years
22 things have changed radically.

23 If you had asked that question

1 five, seven years ago, it would have been
2 up for grabs. But things have changed
3 radically with the flood of credible
4 scientific evidence pouring in from
5 Europe to now -- if -- if five years from
6 now, having seen that information,
7 surgeons persist in doing transgender
8 surgery, then I would -- then I would
9 have real issues with that, as I would
10 with a -- with a general surgeon offering
11 a Billroth II ulcer operation today when
12 you could give the patient erythromycin
13 and some -- and some Zantac. You see
14 where I'm going.

15 So we're at a -- we're at a
16 tipping point in the world of plastic
17 surgery right now, and the last three
18 years have changed everything, because
19 the very, very well-supported -- see, the
20 problem is quality of evidence. Plastic
21 surgeons in America are operating with
22 scientific evidence that even the
23 American Society of Plastic Surgery

1 characterizes as level 5 evidence,
2 basically, the -- the professional
3 opinions based on personal experience.
4 This is entry-level science for a
5 particular therapy or a particular
6 intervention.

7 To raise to level 4, you would
8 have to have the same collected cases
9 with -- with before and after tests of
10 the patient. We haven't gotten to that
11 level yet. There are no long-term
12 longitudinal studies in the American
13 literature. It's all in the European
14 literature, and the bulk of it in the
15 last three years.

16 So the question is a difficult
17 one to answer. As simply as saying that
18 all of these people are immoral, I'm not
19 saying that at all. I'm saying that
20 they're doing the best that they know how
21 according to the training that they've
22 received for people that they very much
23 care for and are hoping to do good by.

1 But the -- but the world is changing
2 rapidly now, and we've reached a stage
3 now where it's such a controversy that
4 this is -- this is -- this is why I've
5 become so publicly vocal about it,
6 because the controversy is now raging.
7 It's no longer: "Maybe so. Milton
8 Edgerton, interesting guy. You know, the
9 surgery at UVA, the surgery at Johns
10 Hopkins, let's get a look at that kind of
11 thing." We've gone beyond that now, and
12 just in the last three years.

13 So I -- the people who do these
14 surgeries are not right out of residency
15 training. These are people who have --
16 you know, who have been in the -- in the
17 business for a number of years now, and
18 they're relying on what they learned and
19 doing the best that they can. But as I
20 say, the science is changing everything,
21 so.

22 MR. TISHYEVICH: With respect,
23 I'm going to strike that answer as not

1 responsive.

2 Q. Here's the -- here's --

3 MR. KNEPPER: No.

4 Q. -- the question that I'd like
5 you to answer.

6 MR. KNEPPER: Go ahead.

7 Q. Here's the question that I'd
8 like you to answer. Is it your expert
9 opinion that the surgeons that are today
10 performing gender-affirming surgical
11 procedures are committing or potentially
12 committing misconduct, yes or no?

13 MR. KNEPPER: Objection, form,
14 scope, asked and answered. Dmitriy, you
15 asked him. He gave you a --

16 MR. TISHYEVICH: I don't need
17 the speaking objections. I do not need
18 the speaking objections.

19 Q. Answer my question, Doctor.

20 MR. KNEPPER: He gave you a
21 thoughtful answer.

22 A. Okay. If you could ask me the
23 question again, I want to be sure that

1 I -- I answer it as succinctly as I can.

2 Q. Is it your expert opinion that
3 the surgeons that are performing
4 gender-affirming surgical procedures
5 today are potentially committing
6 professional misconduct, yes or no?

7 MR. KNEPPER: Objection, form.

8 A. I would -- I would say, only to
9 the extent that they're familiar with the
10 more recent literature would make them
11 sort of culpable, if you will. Not --
12 not being aware of that literature, I
13 would not accuse them of such a thing.

14 Q. All right. Let me introduce
15 another exhibit. Let me know when you
16 get this one, Doctor, Exhibit 9.

17 (Exhibit 9 was marked for identification
18 and is attached.)

19 A. All right. The first page of
20 my -- well, that's the CV, I guess. My
21 CV, yes.

22 Q. This is a copy of your CV;
23 right?

1 A. Yeah. Yes.

2 Q. You prepared this?

3 A. Well, it was prepared for me by
4 -- I gave -- I gave the factual input for
5 it, but I didn't prepare it myself, let's
6 say.

7 Q. Top of the page says, "Board
8 Certified in Surgery and Plastic Surgery"
9 again; right?

10 A. Right. Same mistake, yeah.

11 Q. We agree that's not consistent
12 with guidance from the American Board of
13 Surgery, American Plastic Board of
14 Surgery; correct?

15 MR. KNEPPER: Objection, form.

16 A. Yes.

17 Q. Go to page 3, the bottom of the
18 page. It says, "Publications - Peer
19 Reviewed Medical Journals." You see
20 that?

21 A. I do.

22 Q. And then through page 4, it
23 lists six publications; right?

1 A. Right.

2 Q. In your professional career,
3 you've published six articles in
4 peer-reviewed medical journals; right?

5 A. Right.

6 Q. First one was in 1997; right?

7 A. '87. Yes.

8 Q. Most recent one was in 1998;
9 correct?

10 A. Correct.

11 Q. That's 23 years ago; right?

12 A. Right.

13 Q. You have not published any
14 original research in peer-reviewed
15 literature within the last 23 years;
16 correct?

17 A. Correct.

18 Q. All right. Let's go through
19 these in reverse order. All right. Most
20 recent one from '98 is titled "Treatment
21 of an isolated outer table frontal sinus
22 fracture using endoscopic reduction and
23 fixation." Right?

1 A. Yes.

2 Q. That publication doesn't relate
3 to gender-affirming surgery or to gender
4 dysphoria; correct?

5 A. Tangentially, it would relate to
6 it. And I would say this about it. It
7 was one of the first, if not the first,
8 paper demonstrating the use of endoscopic
9 technique to operate on facial bones of
10 the forehead and the use of internal
11 fixation devices for modification or
12 repair of the forehead. Those are the
13 same techniques that are now used by
14 transgender surgeons who are offering top
15 surgery. For example, for feminization
16 of a masculine brow ridge, they use
17 endoscopic technique, which is described
18 in this paper that came out 23 years ago
19 and was written by myself and another
20 Navy surgeon.

21 Q. Understood.

22 A. Yeah.

23 Q. The -- the patient in this

1 publication was not treated for face --
2 for gender dysphoria obviously; right?

3 A. No. She was a sweet pizza maker
4 who had slipped in the kitchen and struck
5 her head on a stainless steel table and
6 had a -- had a displaced fracture of her
7 forehead. But no, she was -- not to my
8 knowledge. I don't know if she was or
9 not, but to my knowledge, she was not.

10 Q. Next one going backwards is from
11 1996, and it's titled, "Scarless Fetal
12 Skin Repair: 'Unborn Patients' and 'Fetal
13 Material.'" Do you see that?

14 A. I do.

15 Q. All right. That doesn't relate
16 to gender-affirming surgery or to gender
17 dysphoria, I take it?

18 A. It -- it actually refers to all
19 forms of surgery and particularly,
20 ethical decision-making. So I would say
21 that it's -- it's a -- it's a fairly
22 broad paper that talks about how we treat
23 other human persons. So transgender

1 surgery is all about how we treat other
2 human persons. That's what that paper is
3 about and how -- how some surgeons are
4 likely -- or possibly physicians and
5 surgeons could characterize someone as
6 less than human, which is a -- which is a
7 danger that transgender persons
8 experience when they're seeking care.
9 And so I would say that in a very
10 tangential way, it does. It does impinge
11 upon the field of transgender medicine
12 precisely for the reason that transgender
13 persons suffer oftentimes from being
14 treated as -- as someone who is less than
15 human.

16 Q. Aside from that very tangential
17 angle, this paper does not specifically
18 relate to gender-affirming surgery or
19 gender dysphoria; correct?

20 A. No, it does not.

21 Q. And the next one before that is
22 in 1995. Do you see that?

23 A. I do.

1 Q. You're listed as the third
2 author in this one; right?

3 A. Yes, sir.

4 Q. Because you're not the lead
5 author; right?

6 A. No. The attending surgeon is
7 always the lead author, and I was a
8 resident. I was a resident at that time,
9 yeah.

10 Q. Understood. This one's titled
11 "Delayed development of an ectopic
12 frontal sinus mucocoele after pediatric
13 cranial trauma."

14 A. Mucocoele, yes. Mucocoele.

15 Q. Thank you. This publication
16 doesn't relate to gender-affirming
17 surgery or gender dysphoria; correct?

18 A. Not directly, no.

19 Q. Okay. Next one before that is
20 titled "Patch Esophagoplasty"?

21 A. Very good.

22 Q. And that's repair or
23 reconstruction of the esophagus; right?

1 A. Yes.

2 Q. Does this relate to
3 gender-affirming surgery or gender
4 dysphoria?

5 A. No.

6 Q. Next one before that is titled
7 "Modified Skin Incisions for Mastectomy:
8 The Need for Plastic Surgical Input in
9 Preoperative Planning." Do you see that?

10 A. I do.

11 Q. And finally, your oldest
12 publication is from 1987, titled
13 "Peritoneal Fluid in Human Acute
14 Pancreatitis." Do you see that?

15 A. Yes.

16 Q. Does that relate to
17 gender-affirming surgery or gender
18 dysphoria?

19 A. It does not. By the way,
20 that -- that second to the last article,
21 your pattern of questions, I wondered if
22 you overlooked asking the same question
23 on that paper.

1 Q. No. I want to ask you more
2 specific questions about that one, so
3 we'll spend --

4 A. Oh, okay.

5 Q. -- more time on that one.

6 A. Good. Good. Very good. All
7 right.

8 Q. Don't worry.

9 A. Yeah. "Peritoneal Fluid in
10 Acute Pancreatitis" was a research paper,
11 animal model, and review of the
12 literature. Yeah.

13 Q. Okay. You agree there's a
14 difference between a scientific article
15 that reports original research versus a
16 letter to the editor that's published in
17 a scientific journal?

18 MR. KNEPPER: Objection, form.

19 A. Yes.

20 Q. Some of your publications listed
21 here are just letters to editors; right?

22 A. Yes.

23 Q. Why is it that your CV doesn't

1 identify those as letters as opposed to
2 original research?

3 A. I didn't -- that didn't occur to
4 me to do that. Do we generally list them
5 separately? I don't know. I just put
6 all my publications there.

7 Q. So we can look at them, but for
8 example, the scarless fetal skin repair,
9 that's a letter to the editor; right?

10 A. Right.

11 Q. And so is the 1993 publication
12 on patch esophagoplasty; right?

13 A. Right.

14 Q. So out of the six publications
15 that you list in your CV, at least two of
16 them are letters to editors rather than
17 original research; fair?

18 MR. KNEPPER: Objection, form.

19 A. Right. Yes.

20 Q. Okay. Let's talk about your
21 experience treating transgender patients.
22 You retired from the military in 2002;
23 correct?

1 A. Correct.

2 Q. In 2002, the U.S. military
3 certainly was not providing any
4 gender-affirming treatment to anyone in
5 the military; right?

6 A. That's correct.

7 Q. Or to veterans; right?

8 A. Correct.

9 Q. In fact, at that time, there was
10 a policy not to provide gender-affirming
11 treatment to active military or to
12 veterans; correct?

13 MR. KNEPPER: Objection, form,
14 scope.

15 A. Correct.

16 Q. So during your career in the
17 military, you did not provide any
18 gender-affirming treatment to any
19 patients; correct?

20 A. Correct.

21 Q. All right. Let's focus on your
22 practice after you left the military in
23 2002. You currently run the Lappert Skin

1 Care clinic; right?

2 A. That's correct.

3 Q. How long have you operated that
4 clinic?

5 A. One year.

6 Q. Did you operate any clinics
7 before opening this one?

8 A. Yes.

9 Q. What was that one?

10 A. That was my plastic surgery
11 office called Lappert Plastic Surgery in
12 Madison, Alabama. And before that, it
13 was under the same name but located in
14 Decatur, Alabama. And before that, it
15 was in Scottsbluff, Nebraska, same name.

16 Q. How long did you run the Lappert
17 Plastic Surgery clinic?

18 A. The Madison office was for 15
19 years. I'm sorry. The Madison office
20 was for ten years. My -- my mistake.
21 Ten years at the Madison office, five
22 years at the Decatur office, and three
23 years at the Scottsbluff office.

1 Q. So, let me just make sure I have
2 my timing here. So you've had the
3 Lappert Skin Care clinic for a year,
4 since 2020?

5 A. Right.

6 Q. And then the Lappert Plastic
7 Surgery ten years in Madison, so roughly
8 2010 to 2020?

9 A. That's right.

10 Q. And then five years before that
11 in Decatur, 2005 --

12 A. Right.

13 Q. -- to 2010, roughly?

14 A. Right.

15 Q. And then --

16 A. Scottsbluff was from 2002
17 through two -- through 2005. That was
18 where I went when I retired out of the
19 Navy.

20 Q. Your -- your skin clinic
21 currently does treatments like Botox,
22 light therapy, laser hair removal; right?

23 A. Right. Laser tattoo removal,

1 injectables, just skin consultations for
2 skin problems like rosacea, acne, that
3 sort of thing. That's right.

4 Q. Were you performing similar
5 treatments at the Lappert Plastic Surgery
6 clinic?

7 A. Yes. All I've done is I've just
8 suspended -- I just retired from active
9 surgical practice. I had an operating room in
10 my office in Madison as well as in
11 Decatur previously, so I would do both
12 hospital-based surgeries as well as
13 clinic-based, office-based procedures.

14 Q. So for example, light therapy
15 services, you've offered that for
16 ten-plus years, I take it?

17 A. I believe we got that instrument
18 in 2006.

19 Q. How about Botox? Have you been
20 offering that for more than ten years?

21 A. Yes.

22 Q. Have you done forehead
23 injections for more than ten years?

1 A. With Botox?

2 Q. Yes.

3 A. Yes.

4 Q. How about crow's feet? Is that
5 the right term?

6 A. Yes.

7 Q. More than -- more than ten
8 years?

9 A. Yes.

10 Q. When was the last time you've
11 performed a surgical procedure?

12 A. Well, as I said, I retired from
13 surgery in August of 2020, so it was -- I
14 think I was doing some last procedures in
15 that same month, perhaps July, somewhere
16 in there.

17 Q. And in 2020, roughly how many
18 surgical procedures do you think you've
19 performed?

20 A. From January to July?

21 Q. Yes.

22 A. Let's see. Seven months.

23 Perhaps -- I don't know. Maybe eighty,

1 something 80 to 100, I'm guessing. I
2 don't know.

3 Q. And give me examples of common
4 surgeries you would have performed in
5 2020.

6 A. Well, among the most common ones
7 that we did in the -- in the office were
8 autologous fat grafting for recon- -- for
9 rejuvenation of the face, autologous fat
10 grafting for breast augmentation,
11 ultrasound -- I'm sorry -- laser
12 lipoplasty for body contouring, and then
13 many in-office surgical procedures for
14 skin cancer and skin cancer
15 reconstruction, particularly of the face
16 and the extremities.

17 And then on the hospital side, I
18 would be guessing how many, but it was
19 common for me to do breast reductions and
20 abdominoplasties, little local flap
21 reconstructions in the hospital for
22 younger patients who needed anesthesia,
23 reconstruction -- little reconstructive

1 flaps for trauma or for cancer.

2 I had a working relationship
3 with a dermatologist who did a lot of
4 what's called Mohs surgery for removal of
5 cancers. He would send me his patients
6 if they -- if they were cancers that
7 involved the face. I would do those
8 reconstructive surgeries.

9 Yeah, that was probably -- I was
10 definitely throttling back in my last
11 year. I didn't take on a lot of complex
12 cases, so.

13 Q. Okay.

14 A. Because I needed -- you need
15 follow-up, and so limited.

16 Q. I understand. Let's go back to
17 your report. Go to page 4.

18 A. Okay.

19 Q. Okay. Five lines down, you see
20 the sentence starting with, "In my
21 private practice"?

22 A. Yes.

23 Q. Okay. Let's break this down.

1 So you reference treated skin
2 pathologies. What skin pathologies are
3 you referring to here?

4 A. Skin can- -- well, surgically or
5 medically, we're talking two different
6 categories, but. So I'm consulted on --
7 on a lot of nonsurgical skin pathologies.
8 But as far as surgical skin pathologies,
9 that would include various forms of
10 malignancy and then benign growths and
11 things that are either aesthetically or
12 -- aesthetically problematic or
13 suspicious in appearance, so both proven
14 cancers and things that are suspicious of
15 cancers. So those would be the skin
16 conditions. The medical --

17 Q. Yeah. Well --

18 A. -- skin conditions -- I'm sorry?

19 Q. Yeah. That's all right. I'm
20 asking more specifically.

21 A. Okay.

22 Q. Because here, you write, "I've
23 had occasion to treat many

1 self-identified transgender patients for
2 skin pathologies related to their use of
3 high dose sex steroids."

4 A. Yeah.

5 Q. So focusing specifically on that
6 patient population.

7 A. Okay.

8 Q. So, what skin pathologies are
9 you referring to here with respect to
10 transgender patients?

11 A. Well, I've had a few patients
12 who've come in evidencing, you know,
13 acneiform conditions of the facial skin.
14 And so helping people manage acne is a
15 common thing that I do, and a variety of
16 interventions including, you know, the
17 light therapy, but more -- more properly,
18 the use of medications and -- and
19 sometimes laser therapy to manage
20 scarring. But in those particular cases
21 of the trans-identified people, it's
22 mostly just ordinary management of acne.
23 And it's usually the same patients who

1 come to see me about facial hair removal
2 with laser. I have a couple of patients
3 in that category, people who are
4 transitioning and who are seeking laser
5 removal of hair from their faces.

6 Q. And you said this is a few
7 patients. How many transgender patients
8 would you estimate you've treated for
9 skin pathologies related to steroids?

10 A. Related to -- to sex steroids?

11 Q. Yes.

12 A. Oh, I don't know. Probably less
13 than half a dozen.

14 Q. Okay. The acne you're referring
15 to, it's essentially a side effect from
16 the steroids; right?

17 A. It's a common side effect of --
18 of -- yeah. Particularly androgen is the
19 most common.

20 Q. So this -- and so you're
21 treating patients with gender dysphoria
22 after they have already decided to follow
23 a certain course of treatment and started

1 taking sex steroids; right?

2 A. Right. Yeah.

3 Q. Okay. And then you say you've
4 done laser therapies for management of
5 facial hair of also the transgender
6 population?

7 A. That's right.

8 Q. Right?

9 A. That's right.

10 Q. And is that also in about half a
11 dozen patients? Or what's you're
12 estimate?

13 A. Yeah. It's not a huge number.

14 Q. Okay. And finally, you say
15 you've done breast reversal surgeries for
16 detransitioning patients. On how many
17 patients have you performed -- strike
18 that.

19 On how many detransitioning
20 patients have you performed the surgery?

21 A. Two.

22 Q. Two. All right. It's not a
23 commonly performed procedure for you;

1 fair?

2 MR. KNEPPER: Objection, form.

3 A. Yeah, no. They -- they started
4 coming to me in that last year of
5 practice, so. Yeah, that -- it's not
6 a -- yeah, it's not a -- it was never a
7 common procedure for me. I did a lot of,
8 you know, implant removals and stuff
9 through my years. It's the same
10 operation. And I've done a lot of
11 gynecomastectomy surgeries. That's also
12 the same operation. But in terms of as
13 it's applied to a trans- -- a
14 transitioned person who wants to revert
15 back to male presentation, very limited
16 experience. But even though it's the
17 same operation, I have only done it for
18 two people.

19 Q. And you said both of those
20 patients were in 2020?

21 A. I believe so, yeah. One of them
22 may have been in 2019. I'm not positive
23 about that.

1 Q. Before 2019 or 2020, you had
2 never had a detransitioning patient come
3 to you to obtain breast reversal surgery;
4 fair?

5 A. I think that's correct, yeah.
6 I'm just trying to think if there was
7 any, but I can't -- I can't recall any
8 other.

9 Q. Okay. Are you aware that modern
10 gender affirmation programs typically
11 have a multidisciplinary team of
12 healthcare providers?

13 A. Yes.

14 MR. KNEPPER: Objection, form.

15 Q. And they usually involve mental
16 health specialists; right?

17 A. Yes.

18 MR. KNEPPER: Objection, form.

19 Q. Endocrinologists?

20 A. Yes, that's my understanding.

21 Q. And oftentimes plastic surgeons
22 if the patient wants to go that route;
23 right?

1 A. Right. That's -- that's my
2 understanding, yes.

3 Q. You personally have never been
4 part of this kind of a multidisciplinary
5 team for any patient with gender
6 dysphoria; correct?

7 A. No. I have always -- I have
8 always turned away personal -- for per-
9 -- well, my understanding of those
10 procedures has caused me to reject
11 offering them to my patients because I
12 don't see them as beneficial. So
13 clearly, I wouldn't want to participate
14 in a multidisciplinary team that's
15 offering therapies that I consider to be
16 incorrect treatments for a condition that
17 deserves our care, so.

18 Q. All right.

19 A. If you want, I can give you a
20 shorter answer. No.

21 Q. Yeah, let's -- you personally
22 have never treated a single patient for
23 gender dysphoria; correct?

1 A. I have never treated a patient
2 with gender dysphoria surgically.

3 Q. Okay.

4 A. Other than the detransitioner.
5 I -- I suspect they were still suffering
6 from dysphoria even though they were
7 detransitioning, but I didn't treat them
8 with surgery to -- per se for that
9 condition the way the transgender teams
10 do. Yeah.

11 Q. When you were providing laser
12 hair removal to trans women, is that
13 providing gender-affirming care?

14 MR. KNEPPER: Objection, form.

15 A. I don't get into the affirmation
16 side of the treatment. I'm simply
17 providing a service to -- to people who
18 -- who I want to have as friends.

19 Believe it or not, it's true. I -- I
20 don't turn anyone away whose -- whose
21 request is -- is within the scope of what
22 I consider moral practice of medicine and
23 surgery, so.

1 Q. So earlier, I asked you, you
2 personally have never treated a single
3 patient for gender dysphoria, and I think
4 you said not surgically. Let me ask more
5 broadly. Not limited to surgery, you
6 have never treated a single patient for
7 their gender dysphoria symptoms; correct?

8 A. Well, I guess if -- if you were
9 to look at laser facial hair removal and
10 consider that in the -- in the spectrum
11 of care, certainly that's -- that's --
12 that's clinic care that's probably
13 improving the emotional life of the
14 patient because they're seeking to
15 present as women. So in that sense, I
16 have, yeah.

17 Q. Nothing outside of laser hair
18 removal?

19 A. No.

20 Q. You personally have never --

21 A. Well, and -- and acne. Because
22 clearly, that's a problem. But in terms
23 of their -- the trajectory of their

1 transition, acne doesn't enter into it.

2 But certainly laser hair removal, yeah.

3 Q. You personally have never sat in
4 any meetings between a provider and a
5 patient where the doctor was trying to
6 diagnose whether the patient has gender
7 dysphoria; correct?

8 A. Correct.

9 Q. You have never sat in any
10 meetings between a provider and a patient
11 discussing their potential treatment
12 options for gender dysphoria; correct?

13 A. No.

14 Q. All right. You're not an
15 endocrinologist; right?

16 A. Correct.

17 Q. You're not a psychiatrist;
18 right?

19 A. Correct.

20 Q. You're not a licensed mental
21 healthcare provider of any kind; right?

22 A. Correct.

23 Q. In your professional day-to-day

1 practice, you do not diagnose mental
2 health conditions of any kind; right?

3 MR. KNEPPER: Objection, form.

4 A. With the exception of what we
5 discussed earlier about body dysmorphic
6 disorder and gender -- gender identity as
7 a subcategory of body dysmorphic
8 disorder, no, I would say I don't.

9 Q. Okay. If some patient thinks
10 that they may have depression or anxiety,
11 you would expect that patient to go to a
12 mental health professional, not to you;
13 right?

14 A. That's my expectation. But
15 again, many depressed people come to
16 plastic surgeons seeking a remedy for
17 their depression thinking that their
18 appearance is the cause of their
19 depression. And it's my duty as a
20 plastic surgeon to recognize those
21 patients and -- and send them to the
22 psychologist, psychiatrist, rather than
23 offering them surgical care, yeah, so.

1 Q. Yeah. I'm asking a slightly
2 different question.

3 A. Okay.

4 Q. If a -- if a patient, for some
5 reason, came to you and asked you to
6 diagnose them with depression or anxiety,
7 I assume you would refer them to a train
8 -- trained mental health professional;
9 right?

10 A. Yes.

11 Q. Because doctors should not be
12 diagnosing patients with mental health
13 conditions if they do not have training
14 in how to diagnose mental health
15 conditions; right?

16 MR. KNEPPER: Objection, form.

17 A. Well, I wouldn't say that,
18 because for example, as a -- as a -- as a
19 surgeon, as a plastic surgeon, we do have
20 to make diagnoses outside of our
21 specialty in order to get people to the
22 right specialist. So to an extent, you
23 have to make that diagnosis.

1 So for example, as a resident in
2 training, I diagnosed an endocrinological
3 disease and probably saved a woman's life
4 because she was in a psych ward, and --
5 and -- and the doctors had a question
6 about her -- a lump in her neck. She had
7 been on the psych ward for weeks, and I
8 diagnosed a hyperfunctioning thyroid
9 nodule. I didn't confirm that diagnosis.
10 I sent her to an endocrinologist. But I
11 made the initial diagnosis of
12 hyperfunctioning thyroid nodule, and --
13 and ultimately, I did her thyroidectomy.
14 But that's an example.

15 You have to understand pathology
16 outside your specialty because you don't
17 know why the patient is going to present
18 to you, and you have to be ready to start
19 the process that gets them to the
20 specialist, so you have to have a working
21 knowledge of the problems.

22 Q. Yeah, that's exactly the point.
23 Even for that one example, you still send

1 this patient to a trained endocrinologist
2 to confirm the diagnosis; right?

3 A. Right. And then they sent them
4 back to me to give them definitive care.

5 Q. Yeah. And that's what you would
6 do for any patient that presents to you
7 with a mental health condition; right?
8 You would train -- you would send them to
9 someone who is -- who is trained in how
10 to diagnose mental health conditions;
11 right?

12 MR. KNEPPER: Objection, form.

13 A. Yes.

14 Q. You're not trained in providing
15 psychotherapy counseling; right?

16 A. Right.

17 Q. You've never provided
18 counseling, psychotherapy counseling to
19 children or adolescents with gender
20 dysphoria; right?

21 A. Right.

22 Q. You've never provided
23 psychotherapy counseling to adults who

1 have gender dysphoria; right?

2 A. Right.

3 Q. You do not have the professional
4 training to provide psychotherapy
5 counseling to adults who have gender
6 dysphoria; right?

7 MR. KNEPPER: Objection, form.

8 A. Correct.

9 Q. Or to children or adolescents
10 with gender dysphoria; right?

11 MR. KNEPPER: Objection, form.

12 A. Correct.

13 Q. Go to page -- back to your --
14 strike that.

15 Back to your report on page 4,
16 in this paragraph 9, about six lines
17 down, you say, "I have consulted with
18 families with children who are
19 experiencing gender discordance." Do you
20 see that?

21 A. Yes.

22 Q. Describe these consultations for
23 me at a high level.

1 A. Basically, it was families that
2 wanted to understand what -- the nature
3 of plastic surgery sort of in the future
4 for their children. These were -- these
5 were personal encounters rather than in
6 the office, but fairly lengthy at times,
7 talking to families about -- they wanted
8 to understand what was being offered to
9 their children. They wanted to
10 understand the nature of -- or what the
11 future would look like for their
12 children. They wanted to get some idea
13 of -- basically, they wanted to hear sort
14 of a fuller explanation of the -- of the
15 medical and surgical side of things. So
16 I wasn't giving them psychiatric
17 counseling, but basically offering them
18 my experience as a plastic surgeon,
19 wanting to know what the surgery's about,
20 what the -- the hormone therapy that
21 precedes the surgery's about, that sort
22 of thing.

23 Q. How many of these consultations

1 have you done, would you estimate?

2 A. Perhaps five or six, maybe more.

3 Maybe -- yeah, five or six would be a
4 fair number, I think.

5 Q. Over what years?

6 A. Perhaps the last three.

7 Q. Do you know how these parents
8 know to reach out to you for these
9 consultations?

10 A. It's -- I think maybe some of
11 them were -- having heard about my public
12 presentations at various venues. People
13 hear about this plastic surgeon in
14 Decatur who's raising objections, I
15 guess. I don't know the particular
16 details about how a particular patient
17 might have come to me. I just -- I just
18 always make myself available when people
19 are anxious for their children and
20 they're looking for an understanding of
21 what transgender is about.

22 Q. What's the typical advice that
23 you give to parents of children or

1 adolescents who are considering starting
2 puberty blockers?

3 A. Well, my advice on that score is
4 based on the -- on the world literature,
5 that the desistance rate for their child,
6 if they don't give them puberty blockers,
7 the likelihood is that by the time they
8 reach mid-adolescence, they have an 80
9 percent likelihood of desisting in their
10 cross-sex self-identification. And if
11 you follow them into young adulthood,
12 that percentage will be in the 90s.

13 But essentially, I recommend
14 that they slow everything down, and I
15 recommend against the use of puberty
16 blockade because it's experimental and
17 because the likelihood is very high -- in
18 fact, if I had any medical procedure that
19 gave me 90-plus percent success rate, I
20 would consider that a great victory.
21 So -- so that's -- that's what I speak to
22 them about.

23 That -- that desistance data is

1 a very important thing for parents to
2 understand. And very often, the patient
3 -- the parents are experiencing
4 tremendous pressure from the people
5 they've seen in consultation, a
6 tremendous pressure. And usually, the
7 parents are very distressed about what
8 they're hearing, particularly the -- the
9 fear of suicide and self-harm.

10 Q. Yeah.

11 A. So --

12 Q. You encourage -- yeah, no, I got
13 it. You encourage patients of children
14 who -- or adolescents who experience
15 gender dysphoria not to start them on
16 puberty-blocking drugs; fair?

17 MR. KNEPPER: Objection, form.

18 A. Yeah, I discourage the use of
19 puberty blockade for anything other than
20 precocious puberty or other
21 endocrinopathies.

22 Q. And you also discourage them
23 from pursuing surgical procedures for

1 gender dysphoria; correct?

2 MR. KNEPPER: Objection, form.

3 A. Correct.

4 Q. When you do these consultations,
5 do you talk just to the parents or to the
6 children as well?

7 A. Both, yeah. I like to meet the
8 children and -- and -- and get to know
9 them, yeah.

10 Q. And do you convey the same
11 message to the children? Don't start
12 puberty blockers; don't start -- don't do
13 any surgical procedures?

14 MR. KNEPPER: Objection.

15 A. I -- I generally don't -- I'm
16 sorry. I generally don't speak about the
17 details of therapy to children. I speak
18 to their parents.

19 Q. How many children do you think
20 you have consulted with specifically?

21 A. On this -- on this issue?

22 Q. Yes.

23 A. As I say, maybe six. I often --

1 well, yeah, I would say six is a good
2 number.

3 Q. Do you know how many of them
4 went on to start hormone-blocking
5 therapy, if any?

6 A. I don't. I don't know the
7 answer to that question. Yeah, I don't.

8 Q. Do you know how many of them, if
9 any, went on to start cross-sex hormone
10 therapy?

11 A. I don't know the answer to that
12 question, no.

13 Q. You don't know how many of them
14 went on to do any kind of surgical
15 gender-affirming procedures?

16 A. No.

17 Q. You haven't done any follow-up
18 with any of these families that you've
19 consulted?

20 A. As I say, this was an informal
21 thing, so. Yeah. So no, I -- I haven't
22 followed up long-term. This has -- as I
23 say, this has happened over the last

1 perhaps three years. And so the general
2 course of events there is -- is typically
3 longer than that, so. But I have not
4 seen -- well, I have seen one -- one
5 child twice, actually, with the parents.
6 And actually -- okay. So -- so perhaps
7 she would be an exception.

8 She was sort of headed in the
9 direction of seeking puberty blockade.
10 And then in our meetings, she has sort of
11 given that up. She was under a lot of
12 pressure at school, you know, being
13 pressured by boys because she was
14 starting to develop secondary sex
15 characteristics, and she developed a
16 tremendous anxiety about it. And someone
17 had told her that -- that if she went
18 through transition care, that that would
19 be avoided. And I had a conversation
20 with her parents, I had a conversation
21 with her, and essentially just encouraged
22 her to slow down and sort of examine her
23 other options. And I think within about

1 seven months, she came back to me, and
2 she's not even thinking along those lines
3 any longer. In fact, now she's talking
4 about what high school she wants to go
5 to, so.

6 Q. Okay. So this is one child who
7 was considering, or whose parents were
8 considering starting puberty-blocking,
9 but after consultation with you, decided
10 not to; right?

11 A. I think that she -- yeah.

12 MR. KNEPPER: Objection to form.

13 MR. TISHYEVICH: Okay. All
14 right off the record.

15 THE VIDEOGRAPHER: This is the
16 end of Media Unit No. 2. We are off the
17 record at 11:06 a.m.

18 | (Break taken.)

Q. (By Mr. Tishyevich) Doctor, you know what facial feminization surgery is;

1 right?

2 A. Yes, I do.

3 Q. You have never performed facial
4 feminization surgery for any transgender
5 patient; correct?

6 A. Correct.

7 Q. You know what facial
8 masculinization surgery is?

9 A. Yes.

10 Q. You have never performed that
11 for any transgender patient; correct?

12 A. Correct.

13 Q. Do you know what transfeminine
14 top surgery is?

15 A. Yes.

16 Q. You have never performed that on
17 a transgender patient?

18 A. No.

19 Q. How about a chest reconstruction
20 surgery? Have you performed that on a
21 transgender patient?

22 A. No.

23 Q. You have never performed a

1 vaginoplasty for a transgender patient?

2 A. No.

3 Q. You have never performed a
4 metoidioplasty for any transgender
5 patient?

6 A. No.

7 Q. You've never performed what's
8 colloquially known as bottom surgery for
9 any transgender patient; correct?

10 A. Correct.

11 Q. Fair to say you've never
12 performed any kind of gender-affirming
13 surgery in transgender patients; right?

14 A. Correct.

15 Q. And fair to say you don't have
16 recent and substantive experience in
17 performing gender-affirming -- affirming
18 surgery for transgender patients;
19 correct?

20 MR. KNEPPER: Form.

21 A. I have -- I have substantive
22 experience with all the actual -- the
23 nature of the particular operations but

1 never performed for transgender patients
2 to transition them, no. But the
3 operations themselves as used in
4 reconstruction, I have considerable
5 experience with.

6 Q. We talked earlier about the
7 American Society of Plastic Surgeons.
8 You recall that?

9 A. I do.

10 Q. You know that the ASPS has a
11 code of ethics?

12 A. Yes.

13 Q. And you know that members are
14 required to comply with the code of
15 ethics; right?

16 A. Yes.

17 Q. And I know you're not a member
18 now, but you were a member of the ASPS
19 for a considerable amount of time; right?

20 A. Yes.

21 Q. And I assume during that time,
22 you followed the ASPS code of ethics;
23 right?

1 A. To my knowledge, I never
2 violated it. Yes.

3 Q. When was the last time you
4 reviewed it?

5 A. I'm sorry, did I lose the sound
6 here?

7 Q. When was the last time you
8 reviewed the ASPS code of ethics?

9 A. Oh, gosh. Years ago. Years
10 ago.

11 Q. Let me introduce an exhibit.

12 Let me ask you this first. Are
13 you aware that the ASPS code of ethics
14 had some specific rules for members who
15 provide expert testimony?

16 A. Yes.

17 Q. Okay. You didn't review those
18 provisions before you formed your expert
19 opinions in this case?

20 A. No.

21 Q. Sitting here today, do you know
22 if your opinions in this case are in
23 compliance with what the ASPS code of

1 ethics says about members who provide
2 expert testimony?

3 A. I'm not aware that I've violated
4 them in any way, yeah.

5 Q. Let me introduce an exhibit.

6 Okay. Let me know when you have it.

7 (Exhibit 10 was marked for identification
8 and is attached.)

9 A. Okay.

10 Q. It's still opening on my end.

11 Okay. So, Exhibit 10 is the
12 Code of Ethics of the American Society of
13 Plastic Surgeons. You see that?

14 A. I do.

15 Q. The bottom left corner says,
16 "Updated September 25, 2017." See that?

17 A. I do.

18 Q. That's when you were still an
19 active member of the ASPS; right?

20 A. Yeah, that's right.

21 Q. Go to page 4.

22 A. I think I'm on page 4 here.

23 They're not numbered. Oh, here we are,

1 yes.

2 Q. Or I'm sorry, page 6.

3 A. Page 6.

4 Q. Section IV.

5 A. Section IV, yes.

6 Q. Section IV is "Expert
7 Testimony"; right?

8 A. Yes.

9 Q. I want to focus you on the last
10 two sentences of this first paragraph.
11 It says, "Members whose testimony,
12 including testimony as to credentials or
13 qualifications, is false, deceptive, or
14 misleading may be subject to disciplinary
15 action, including expulsion." You see
16 that?

17 A. Yes.

18 Q. The next sentence says, "Further
19 to help limit false, deceptive and/or
20 mislead" -- "misleading testimony,
21 Members serving as expert witnesses
22 must," and then there's a list of
23 requirements. You see that?

1 A. I do.

2 Q. Okay. So "must" means this is a
3 mandatory rule, not an optional
4 suggestion; right?

5 MR. KNEPPER: Objection, form.

6 A. I expect that's what it means,
7 yes.

8 Q. All right. Let's look at these
9 rules. Number 1 says that members
10 serving as expert witnesses must "Have
11 recent and substantive experience (as
12 defined in the Glossary of the Code) in
13 the area in which they testify,
14 including, without limitation, experience
15 in the relevant subspecialty or the
16 particular procedure performed on the
17 plaintiff."

18 Do you see that?

19 A. I do.

20 Q. All right. Without looking at
21 the glossary, do you know, sitting here
22 today, how the glossary defines "recent
23 and substantive experience"?

1 A. I don't.

2 Q. Okay. Why don't we look at that
3 definition together. Go to page 8.

4 A . Okay .

Q. See there's subsection F?

6 A. Yes.

7 Q. All right. Read that definition
8 to yourself, and tell me when you're
9 done.

10 A. Okay.

11 | (Witness reviews document.)

12 A. Okay.

13 Q. To be able to provide expert
14 testimony -- well, strike that.

15 Let me focus you on the very
16 last part of this definition. Okay. To
17 be able to provide expert testimony about
18 a particular surgical procedure, the ASPS
19 Code of Ethics requires a surgeon to have
20 performed a specific procedure in
21 question within three years of being
22 retained as an expert witness; correct?

A. That's what it says, yes, sir.

1 MR. KNEPPER: Objection, form.

2 Q. All right. Now, as we've just
3 discussed, you personally have not
4 performed any kind of facial
5 masculinization surgery in the last three
6 years; correct?

7 MR. KNEPPER: Objection, form.

8 A. Correct.

9 Q. Any kind of facial feminization
10 surgery; right?

11 A. Correct.

12 MR. KNEPPER: Objection, form.

13 Q. Vaginoplasty; right?

14 MR. KNEPPER: Objection, form.

15 A. Correct.

16 Q. Metoidioplasty; right?

17 MR. KNEPPER: Objection to form.

18 A. Correct.

19 Q. You personally have not
20 performed any kind of gender-affirming
21 surgical procedure on a transgender
22 patient in the last three years; correct?

23 MR. KNEPPER: Objection, form.

1 A. I have never performed such
2 procedures.

3 Q. All right. Well, given that you
4 have not ever personally performed any
5 kind of surgical procedures in the last
6 three years, I take it you're not
7 offering expert opinions on any of these
8 surgeries because doing so would be
9 inconsistent with the ASPS code of
10 ethics; right?

11 MR. KNEPPER: Objection, form.

12 A. Well, so the ethics that informs
13 my opinion here is I don't derive from
14 the ASPS, nor am I subject to their --
15 their -- what's the word I'm looking
16 for -- their sanctions, I guess, would be
17 the correct word. The expert opinion I
18 offer here is not on -- on complications
19 of an operation that might enter into a
20 litigation. In terms of the -- you know,
21 I guess the -- the question at hand here
22 is transition surgery, the bigger
23 picture. I certainly make record of --

1 of the known complications as available
2 in the literature. And in my testimony,
3 I did a literature review on the
4 complications of particular surgeries.

5 But I don't do these operations
6 for a reason, and the reason I don't do
7 these operations is ethical based on my
8 knowledge of the science. I don't derive
9 my ethical decision-making from the ASPS,
10 and this is one of the reasons why,
11 again, I have no heartburn about having
12 withdrawn my membership. I have great
13 issue with -- with the idea that a
14 professional organization would encourage
15 or sanction these operations given the
16 world literature.

17 Q. Your opinion -- your -- strike
18 that.

19 Your expert report does offer
20 some opinion, or purports to offer some
21 opinions about surgical risks of some of
22 these gender-affirming surgical
23 procedures, does it not?

1 A. Yes. Based on my -- my
2 experience in microvascular surgery, on
3 flap reconstruction of the perineum, for
4 example, flap reconstruction of the chest
5 or the -- or the genital area in
6 treatment for traumatic injuries and
7 things. So the operations themselves,
8 I'm quite familiar with. I'm quite
9 familiar with the complications that are
10 peculiar to free flap or local flap
11 reconstructions.

12 But as far as doing those
13 operations for gender transitioning, I --
14 I don't do those operations. But the
15 complications are the same: flap loss,
16 flap necrosis, urinary fistulas. All of
17 those things I have -- I have experience
18 with in managing trauma, in managing
19 cancer, in managing infectious
20 destruction of the genital area. But
21 I've never done the operation for
22 transgender per se, correct.

23 Q. And because you've never done

1 any of those procedures on transgender
2 patients, can we agree that offering
3 those opinions is inconsistent with the
4 ASPS Code of Ethics?

5 MR. KNEPPER: Objection, form.

6 A. I would not agree with that.

7 Q. Does it bother you that you
8 might be in violation of the Code of
9 Ethics by offering these opinions?

10 MR. KNEPPER: Objection.

11 A. No. Not in the least.

12 Q. Do you think that a judge might
13 be troubled by the fact that your
14 professional organization, former
15 professional organization, says you
16 shouldn't be allowed -- you shouldn't be
17 offering these kind of opinions?

18 MR. KNEPPER: Objection, form.

19 A. Yeah, I find -- I find the --
20 the whole situation troubling, and I
21 would hope that the judge would be
22 troubled by it, yes.

23 Q. Okay. Yeah, no, I mean, I'm

1 asking a much more specific question.
2 The judge is going to be asked to find
3 whether your testimony is reliable. Do
4 you think the judge might have some
5 concerns if she -- if they were to
6 conclude that the testimony you're
7 offering in this case is not allowed
8 under the code of ethics of the ASPS?

9 MR. KNEPPER: Objection, form.

10 A. I -- I -- I haven't thought
11 about it.

12 Q. And you haven't thought about it
13 because before today, you didn't know
14 whether or not your testimony complies
15 with the ASPS Code of Ethics; right?

16 MR. KNEPPER: Objection, form.

17 A. I was not -- I was not concerned
18 with the ASPS Code of Ethics, for reasons
19 we've discussed earlier.

20 Q. Did you know that -- did you
21 know that the ASPS Code of Ethics
22 prohibits members from offering expert
23 testimony on topics in which they do not

1 have recent and substantive experience?

2 MR. KNEPPER: Objection, form.

3 A. Could you -- can you -- I want
4 to make sure I answer your question and
5 not something else. Could you offer me
6 that question again, please?

7 Q. Before I showed you this code of
8 ethics at your deposition today, were you
9 aware that the ASPS Code of Ethics
10 prohibits members from offering expert
11 opinions on topics on which they do not
12 have recent and substantive experience?

13 MR. KNEPPER: Objection, form.

14 A. Actually, I dreaded that such a
15 -- such a fact would come to light. I
16 have not read the -- the ethics code in
17 recent years, as I said earlier. But
18 I -- I have dreaded this evolution in the
19 ethics of my former professional society,
20 that they would consider transgender
21 surgery the way they do.

22 I -- other -- aside from that, I
23 was not concerned that I might be

1 violating the ethics of the society
2 because in all my previous life, I have
3 never violated the ethics of the society.

4 And I don't -- at present, I don't
5 consider my testimony to be a violation
6 of this policy that we've read together.

7 Q. I understand. All right. Let's
8 switch gears. You know what the WPATH
9 is? The World Professional Association
10 for Transgender Health?

11 A. Yes.

12 MR. TISHYEVICH: And for the
13 court reporter, it's W-P-A-T-H, all
14 capital.

15 Q. All right. You know that the
16 WPATH publishes standards of care for the
17 health of transgender people; right?

18 A. They have a publication that
19 they call the standards of care, yes.

20 Q. And are you aware that they've
21 been publishing those standards since
22 1979?

23 A. Yes.

1 Q. The latest publicly available
2 standard of care is Version 7; correct?

3 A. Correct.

4 Q. And that was published in 2012;
5 right?

6 A. That's right.

7 Q. All right. Before you wrote
8 your report, did you sit down and review
9 the Standards of Care, Version 7 that
10 you're criticizing?

11 A. Yes, I did.

12 Q. All right. You yourself are not
13 part of the WPATH; correct?

14 A. No, I am not.

15 Q. You've never been part of the
16 WPATH; right?

17 A. I would never be part of the
18 WPATH.

19 Q. You've never advised the WPATH
20 in any capacity; right?

21 A. They've never asked my opinion.
22 No.

23 Q. You've never advised the WPATH

1 in any capacity; correct?

2 A. I have not.

3 Q. You personally have not been
4 involved with the development of WPATH's
5 Standards of Care, Version 7; correct?

6 A. Correct.

7 Q. You don't know what year the
8 WPATH started working on Version 7;
9 right?

10 A. My understanding was it was in
11 2007, but I could be wrong. I think it
12 was 2007. I think it was a five-year
13 process, but I could be wrong on that.

14 Q. You don't know for sure?

15 A. I don't know for sure.

16 Q. You don't know how many
17 different work groups at the WPATH were
18 involved with working on Version 7;
19 correct?

20 MR. KNEPPER: Objection, form.

21 A. In reading the -- the
22 introduction to the document, the number
23 nine pops into my mind, but I can't swear

1 to that.

2 Q. Okay. You don't know what kind
3 of scientific literature the WPATH
4 conducted as part of drafting Version 7;
5 right?

6 A. As far as naming the particular
7 papers that they may have reviewed, I
8 can't do that for you because those
9 are -- that happens in closed committee.
10 I -- all I can say to you is my -- based
11 upon my reading of the product and the
12 verbiage that it's used, my suspicion is
13 that it's pretty heavily weighted towards
14 the American literature and -- and does
15 not bring in particular document -- well,
16 being that it was published in 2012, the
17 big inflection point in 2011 probably
18 wasn't available to the committee when
19 they were writing that document.

20 So given that the document is
21 already out of date and it's -- and the
22 subsequent WPATH 8, no one knows when
23 it's going to come out, yeah, it's --

1 it's almost -- it's almost irrelevant
2 because of the change in the literature
3 that happened since it was published, so.
4 In particular, the 2011 article by
5 Dhejne, Cecilia Dhejne, and -- and others
6 that kind of changed the view of the
7 scientific evidence.

8 So yeah, it's an out-of-date
9 document by the standards of what are
10 called standards of care. It's not a
11 standards of care document. It's a --
12 it's a treatment guideline document is
13 really what it is, and it's a poorly
14 supported treatment guideline at that,
15 so -- gosh, I wandered off.

16 Did I -- did I answer your
17 question?

18 Q. Yeah, you anticipated my
19 objection.

20 MR. TISHYEVICH: Which, again,
21 I'll move to strike most of that as
22 nonresponsive.

23 Q. Because here's my question. You

1 don't personally know what kind of
2 scientific literature the WPATH conducted
3 as part of drafting Version 7; correct?

4 MR. KNEPPER: Objection, form.

5 A. No. Again, a closed session, so
6 I don't know what documents they used.

7 Q. You don't know what kind of
8 outside experts the WPATH may have
9 consulted in drafting Version 7; right?

10 A. No.

11 Q. You don't know what kind of peer
12 review the WPATH may have conducted as
13 part of developing Version 7; right?

14 MR. KNEPPER: Objection, form.

15 A. No.

16 Q. You don't know what kind of
17 public comments the WPATH may have
18 solicited as part of developing Version
19 7.

20 MR. KNEPPER: Objection, form.

21 Q. Right?

22 A. No.

23 Q. You don't know how many

1 different drafts the Version 7 went
2 through before it was finalized; right?

3 A. No.

4 Q. You don't know how many
5 different meetings or conferences the
6 WPATH had to discuss the development of
7 Version 7; right?

8 A. Correct.

9 Q. You have no idea what may have
10 gone on during those meetings or
11 conferences; correct?

12 MR. KNEPPER: Objection, form.

13 A. No. I was not a part of the
14 conferences that produced the product.

15 Q. Yeah, you are not an expert in
16 how Version 7 of the WPATH was developed;
17 right?

18 A. Correct.

19 Q. And we can go through all these
20 questions again individually for Version
21 8, but maybe we can shortcut this.

22 A. Well, no one knows what's in
23 Version 8 except the people who are in

1 the committee. It's a -- it's a
2 privileged document. There's no one in
3 plastic surgery who knows it apart from
4 the people who serve as members of the
5 WPATH, so that would be the case.

6 Q. Okay.

7 A. It's a -- it -- yeah.

8 Q. So just so we have it on the
9 record, you don't hold yourself out as an
10 expert on how Version 8 of the WPATH
11 Standards of Care are currently being
12 developed; fair?

13 A. Fair.

14 Q. Okay. We talked earlier about
15 the DSM; right?

16 A. Yes.

17 Q. In your day-to-day practice, you
18 don't use the DSM-5; correct?

19 A. No.

20 Q. But you do know the DSM-5 is
21 widely used by psychiatrists; correct?

22 A. Yes.

23 Q. The DSM-5 was published in 2013;

1 | correct?

2 A. I don't know the publication
3 date, but it sounds about right.

4 Q. Do you know that it was
5 developed by the American Psychiatric
6 Association?

7 A. Yes.

8 Q. You're not a member of the APA;
9 right?

10 A. Correct.

11 Q. You personally have not been
12 involved with the development of DSM-5;
13 right?

14 A №

15 Q. You don't know how many
16 different working groups were involved
17 with developing the DSM-5; right?

18 MR. KNEPPER: Objection, form

19 A Correct

20 Q. You don't know how many
21 different members those working groups
22 had: right?

MR. KNEPPER: Objection form

1 A. No.

2 Q. Or how they were selected;
3 right?

4 MR. KNEPPER: Objection, form.

5 A. Correct.

6 Q. You don't know how many
7 different authors contributed to the
8 development of DSM-5; correct?

9 A. Correct.

10 MR. KNEPPER: Objection, form.

11 Q. You don't know what kind of
12 scientific literature review was done by
13 different work groups as part of
14 developing the DSM-5; correct?

15 MR. KNEPPER: Objection, form.

16 A. Correct.

17 Q. You don't know what kind of
18 public comments the APA may have
19 solicited in developing the DSM-5;
20 correct?

21 MR. KNEPPER: Objection, form.

22 A. Correct.

23 Q. You don't know how many

1 different drafts the DSM-5 went through
2 before it was finalized; correct?

3 MR. KNEPPER: Objection, form.

4 A. Correct.

5 Q. You don't know how many
6 different meetings or conferences or
7 telephonic conferences the working groups
8 had to discuss the development of the
9 DSM-5; right?

10 MR. KNEPPER: Objection, form.

11 A. Right.

12 Q. You have no idea what was
13 discussed during any of those meetings;
14 right?

15 A. Right.

16 Q. Let me ask you specifically
17 about the Sexual and Gender Identity
18 Disorders Work Group. First of all,
19 before today, did you know that the APA
20 had a Sexual and Gender Identity
21 Disorders Work Group as part of the
22 development of the DSM-5?

23 MR. KNEPPER: Objection, form.

1 A. Yes.

2 Q. Do you know how many members
3 were in that work group?

4 A. No.

5 Q. You don't know --

6 MR. KNEPPER: Objection.

7 Q. -- how those members were
8 selected; right?

9 MR. KNEPPER: Objection to form.

10 A. Correct.

11 Q. You don't know their expertise;
12 right?

13 A. Correct.

14 Q. You do not have expert firsthand
15 knowledge of how the DSM-5 was developed;
16 fair?

17 MR. KNEPPER: Objection, form.

18 A. Fair.

19 Q. Are you aware that the DSM-4
20 used the term "gender identity disorder"
21 instead of "gender dysphoria"?

22 A. Yes.

23 Q. Do you know the reason for that

1 change?

2 A. From DSM-4 to DSM-5?

3 Q. Yes.

4 A. Yes.

5 Q. What's the reason?

6 A. In reading the literature and
7 reading the reports of perhaps people who
8 served on the committee, because I don't
9 know how else you would be privy to this
10 information, there was a desire on the
11 part of the APA to de-pathologize the
12 condition, and they wanted to use
13 terminology that didn't sound like
14 medical diagnoses. It was the opinion of
15 the members of that committee that --
16 that transgenderism is only a diagnostic
17 issue from the standpoint of the
18 discomfort or the sorrow that the patient
19 feels rather than any underlying
20 pathology. So the -- the desire was to
21 move those -- the diagnosis to change the
22 language of diagnosis to de-pathologize
23 it. But the problem that the committee

1 faces is that having done that, there's
2 no mechanism for providing the services
3 that they felt that the patients needed,
4 so there had to be a diagnose -- a
5 diagnostic code in order to get
6 thirty-part -- third-party payers to pay.
7 So it's a de-pathologize but maintain a
8 diagnostic -- diagnostic code. That's my
9 understanding of it.

10 Again, I wasn't there. But
11 again, reading the writings of people who
12 could only have gleaned it from having
13 been present because it's closed session,
14 that's my understanding.

15 Q. Understood. All right. Do you
16 know what the Endo- -- Endocrine Society
17 guidelines for treatment of
18 gender-dysphoric or gender-incongruent
19 persons are?

20 A. Do I know what they are?

21 Q. Yeah.

22 A. Yes.

23 Q. Do you know when they were

1 initially published?

2 A. No.

3 Q. Do you know when they were last
4 revised?

5 A. I think it was just a couple of
6 years ago, but I don't know the exact
7 date.

8 Q. If I tell you it's 2017, does
9 that sound right?

10 A. That wouldn't -- it wouldn't
11 surprise me if that were true. I -- just
12 within the last couple of years. I think
13 theirs are current, and the expectation
14 is that these standards of care or
15 treatment guidelines will have a
16 five-year revision. So given that
17 they're current, they couldn't be any
18 older than, say, 2017. So I suspect that
19 -- yeah.

20 Q. All right. Did you review the
21 latest available version of those
22 Endocrine Society guidelines before
23 forming your opinions in this case?

1 A. Yes. I have read them, yes.

2 Q. Okay. You yourself are not part
3 of the Endocrine Society; right?

4 A. Correct.

5 Q. Have never been part of that
6 society; right?

7 A. Correct.

8 Q. You've never advised the
9 Endocrine Society in any capacity;
10 correct?

11 A. Correct.

12 Q. You personally were not involved
13 with the development of these original
14 guidelines; correct?

15 A. That's correct.

16 Q. Not personally involved with the
17 development of the updated guidelines in
18 2017; right?

19 A. Correct.

20 Q. Do you know how many people at
21 the Endocrine Society were involved with
22 those 2017 updates?

23 A. I do not know that number.

1 Q. And you don't know how they were
2 selected to work on the 2017 updates;
3 correct?

4 A. Correct.

5 Q. You personally don't know what
6 kind of scientific literature review the
7 Endocrine Society conducted in developing
8 those updates; correct?

9 MR. KNEPPER: Objection to form.

10 A. Correct.

11 Q. You don't know what kind of
12 outside experts they may have used;
13 right?

14 A. What kind of outside experts? I
15 would imagine they were all
16 endocrinologists. Or are you asking did
17 they have plastic surgeon input or --

18 Q. Do you know specifically whether
19 the Endocrine Society used any outside
20 experts in updating the -- in
21 implementing the 2017 updates?

22 A. Well --

23 MR. KNEPPER: Objection, form.

1 A. I can only infer that they
2 would, because such -- such statements,
3 in order to be valid, demand review by
4 outside parties to -- to obviate
5 conflicts of interest, whether financial
6 or professional. Those are all issues
7 when generating standards of care, so of
8 necessity, they would have had to have
9 had outside experts to come in, yes.

10 Q. Okay. Do you know what kind of
11 public comments the Endocrine Society may
12 have solicited as part of developing the
13 2017 updates?

14 A. I don't.

15 MR. KNEPPER: Objection to form.

16 Q. You don't know how many
17 different drafts there were of those 2017
18 updates before they were finalized;
19 right?

20 A. No.

21 MR. KNEPPER: Objection to form.

22 A. No, I don't.

23 Q. Again, you haven't been to any

1 meetings or conferences or telephonic
2 conferences where those 2017 updates were
3 discussed, where the development of those
4 2017 updates was discussed; correct?

5 MR. KNEPPER: Objection to form.

6 A. Correct.

7 Q. You don't know what went on
8 during those meetings or conferences;
9 right?

10 MR. KNEPPER: Objection, form.

11 A. I do not.

12 Q. You -- you're not an expert in
13 how the Endocrine Society developed the
14 original 2009 guidelines for treating
15 gender dysphoria; correct?

16 MR. KNEPPER: Objection to form.

17 A. That's not -- that's not my area
18 of expertise. That's correct.

19 Q. Right. And you're also not an
20 expert in how the Endocrine Society then
21 developed the 2017 updates back to those
22 guidelines; correct?

23 A. Correct.

1 Q. Okay. All right. Now let's
2 talk about puberty-blocking agents. What
3 puberty blocker drugs are you aware of by
4 name?

5 A. Well, Lupron is probably the
6 most widely used one. They're -- they're
7 all gonadotropin-releasing hormone
8 agonists. They come by a variety of
9 trade names. But gonadotropin-releasing
10 hormone is the generic -- I'm sorry, the
11 generic name for the drug that may appear
12 under a variety of, you know, proprietary
13 names, Lupron being the most commonly
14 used.

15 Q. You've never prescribed Lupron;
16 right?

17 A. No, I have never. No.

18 Q. You have never prescribed any
19 puberty-blocking drugs of any kind;
20 right?

21 A. No. That's not my area of
22 expertise.

23 Q. Right. Have you ever looked at

1 the package -- strike that.

2 You know what a package insert
3 is; right?

4 A. Yes.

5 Q. Have you ever looked at a
6 package insert for Lupron?

7 A. Some time ago, but yes, I have.

8 Q. Okay. How recently do you
9 think?

10 A. Gosh, it's probably more than
11 four or five years ago. I think probably
12 when I first started go -- you know,
13 looking into this more carefully back in
14 2014. It was probably that long ago.

15 Q. Do you know what Vantas is?

16 V-A-N-T-A-S .

17 A. Oh, I've read that somewhere
18 before. Let's see. Is it -- it's the
19 adverse events reporting -- is that what
20 I -- I don't --

21 Q. It's a type of drug.

22 A. Oh.

23 Q. So no, that doesn't sound

1 familiar?

2 A. It does not sound familiar, no.

3 Q. How about Triptodur?

4 T-R-I-P-T-O-D-U-R.

5 A. That sounds like a trade name

6 I'm not familiar with.

7 Q. Okay. Fensolvil?

8 F-E-N-S-O-L-V-I-L.

9 A. That sounds like a trade name

10 I'm not familiar with.

11 Q. Trelstar? T-R-E-L-S-T-A-R.

12 A. Same.

13 Q. All right. You're not an expert
14 in the different types of prescription
15 drugs that are used as puberty-blocking
16 agents; fair?

17 A. I do not consider myself an
18 expert in that area, no. I rely on
19 experts.

20 Q. All right. You know that
21 puberty blockers are typically prescribed
22 by endocrinologists; right?

23 A. Yes. Pediatricians and

1 endocrinologists, yes.

2 Q. Right. You have no specialized
3 training or expertise in endocrinology;
4 correct?

5 A. Correct.

6 Q. You don't hold yourself out as
7 an expert in endocrinology; correct?

8 A. No, I do not.

9 Q. You're not planning on offering
10 any expert opinions in endocrinology in
11 this case because that's outside your
12 scope of expertise; right?

13 A. Yes.

14 MR. KNEPPER: Objection to form.

15 Q. All right. Earlier, you said
16 you have never prescribed
17 puberty-blocking agents to anyone, so I
18 take it you have no experience, no
19 firsthand experience with advising your
20 patients about potential risks and
21 benefits of puberty blockers; right?

22 MR. KNEPPER: Objection, form.

23 A. Well, I have talked to patients

1 -- well, families, really, about the
2 risks of puberty blockers in -- in early
3 puberty and into adolescence. I have
4 because I've reviewed the literature and
5 I've spoken with experts in the area.
6 And so, is that the question --

7 Q. Yeah.

8 A. -- you're asking, have I spoken
9 to anybody? Yeah, I have. I -- I have,
10 again, knowing that -- for example, that
11 the drug Lupron, as an example, is -- is
12 -- is not cleared by the FDA for
13 application. It's an off-label use when
14 using it in the diagnosed condition of
15 gender dysphoria. So I know that it's an
16 off-label application of the drug, and I
17 know what the effects of the drug are.
18 But nobody knows what the effects of the
19 drug are on otherwise normal children,
20 and that's pretty much all I'd relate to
21 the families on the -- on that subject.

22 I don't offer myself as an
23 endocrinologist, but I offer myself as a

1 concerned physician who has spoken with
2 the specialists and read the package
3 insert. Yes.

4 Q. You think off-label use is
5 improper; right? That's the sense I got
6 from reading your report.

7 MR. KNEPPER: Objection, form.

8 A. Off-label use in certain
9 situations. So I use -- I use -- I have
10 applied drugs' off-label use many times.
11 But what the -- what the practitioner has
12 to do is weigh the risk/benefit equation
13 there and what is the expected goal and
14 what are the likely risks.

15 For example, I used Botox long
16 ago in the treatment of -- of
17 hyperhidrosis before the company that
18 produces it got FDA clearance to use it
19 that way. The risk, very, very low risk;
20 the potential benefit, very, very high.
21 But in this case, we're talking about
22 very significant risks for an unproven
23 benefit. So that's an example of how you

1 have to weigh off-label use.

2 And the FDA understands that,
3 and they don't go after off-label use
4 unless there's significant risk. And
5 even then, they might not yet spring into
6 action. It's a pretty slow-moving
7 organization.

8 Q. All right. We'll come back to
9 that.

10 A. Okay.

11 Q. You never sat in on any
12 appointment where an endocrinologist
13 prescribed a puberty-blocking drug to a
14 patient; correct?

15 A. I have never.

16 MR. KNEPPER: Objection, form.

17 Q. You personally don't know what
18 endocrinologists typically tell their
19 patients about risks and benefits of
20 puberty blockers; right?

21 MR. KNEPPER: Objection, form.

22 A. Only what I have read in the
23 record. For example, the plaintiffs'

1 records, I -- I -- I believe I have read
2 that -- that kind of consultation, yeah.
3 But I -- but I wasn't present in the
4 room, if that's what your question is.

5 Q. Yeah. You don't know what was
6 actually communicated to the patient;
7 correct?

8 A. Only what was entered in the
9 record, yeah, the medical record.

10 Q. And just as a more -- outside of
11 these plaintiffs, as a more general
12 matter, you don't personally know what
13 endocrinologists tell their patients
14 about potential risks and benefits of
15 puberty blockers because you're not
16 present on those prescribing decisions;
17 right?

18 MR. KNEPPER: Objection, form.

19 A. Well, if -- I assume that they
20 follow the same sort of process that
21 every other medical professional does
22 when getting consent for -- for therapies
23 of various kinds. And so to offer

1 informed consent to a -- in this case,
2 perhaps a family, parents, that informed
3 consent would have to include -- in order
4 to be valid, it would have to include the
5 potential risks that are enumerated in
6 the package insert. And then they would
7 also, in certain cases, have to enumerate
8 risks that may not be in the package
9 insert but may be expected given the --
10 the particular case of their child or the
11 particular patient.

12 So we all have to follow that
13 same general standard, and so to that
14 extent, I have some knowledge of what
15 they would be saying. But the particular
16 words or the particular things they may
17 have emphasized, I have no -- no personal
18 knowledge of.

19 Q. Your general expectation is that
20 before a doctor prescribes the drugs,
21 they will at least inform the patients of
22 the risks as specifically enumerated in
23 the drug labeling; right?

1 A. Among other things, yes.

2 Q. And the doctor may also go
3 beyond the labeling and advise them of
4 potential risks even though they're not
5 specifically disclosed in the drug
6 labeling; right?

7 A. Yes. Because there -- there are
8 circumstances wherein the underlying
9 conditions of the patient may -- may
10 cause particular risks in particular
11 areas, so that's right.

12 So there's the general
13 precautions that are included in the
14 package insert, but they usually tend to
15 be exhaustive. They -- they list in the
16 package inserts even remote
17 possibilities, so. But most physicians
18 can't drill down into those details with
19 a patient. You don't want to overwhelm
20 the patient and their family with those
21 minute details. You want to talk about
22 the major risks and then the risks that
23 are peculiar to the patient because of

1 their underlying condition. And that's
2 generally what everybody does.

3 Q. Yeah.

4 A. Although, again, I'm not present
5 in every office on every occasion, but
6 that's generally how we're trained to
7 conduct a consent.

8 Q. Do you know -- are you aware
9 that patients who are prescribed
10 puberty-blocking agents are typically
11 monitored through blood tests and lab
12 work?

13 MR. KNEPPER: Objection, form.

14 A. It -- I don't -- I'm not
15 familiar in all cases to what extent
16 they're monitored. My hope is that
17 they're being monitored. I would expect
18 that they're being monitored.

19 Q. Yeah. And you don't have
20 experience with monitoring patients who
21 undergoing treatment with puberty
22 blockers; right?

23 A. No.

1 Q. And you don't have experience
2 with reviewing blood work, labs, what's
3 normal, what's not, anything in that
4 field; right?

5 MR. KNEPPER: Objection to form.

6 A. Oh, no, I am familiar with
7 reviewing labs and interpreting
8 laboratory data --

9 Q. Sorry.

10 A. -- as it pertains -- yeah.

11 Q. Sorry. Let me make -- make my
12 question more specific. I'm still
13 talking about patients who are treated
14 with puberty-blocking agents.

15 A. Okay.

16 Q. For those patients in
17 particular, you don't have experience
18 with reviewing their blood work, labs to
19 see -- to check their hormone levels and
20 see if any adjustments are needed; right?

21 MR. KNEPPER: Objection, form.

22 A. No. I have some familiarity
23 with the interpretation of hormone levels

1 in endocrinology. As a -- as a general
2 surgeon and a critical care doctor, these
3 issues were very important to me for a
4 number of years. So I'm familiar with
5 that, although I haven't monitored
6 patients receiving puberty blockers or
7 cross-sex hormones per se. So generally,
8 I am familiar with -- with that and the
9 ramifications of endocrinopathies, again,
10 because I had considerable experience
11 with management of critical care patients
12 and -- yeah.

13 Q. Yeah. My question is more
14 specific.

15 A. Okay.

16 Q. You personally have not
17 monitored blood work from patients who
18 are undergoing puberty-blocking agents;
19 right?

20 A. Correct.

21 Q. Okay. And you mentioned
22 cross-sex hormones. You know what those
23 are; right?

1 A. Yes.

2 Q. For transgender women, estrogen
3 is a hormone that's typically prescribed;
4 right?

5 A. Yes.

6 Q. For transgender men,
7 testosterone is the hormone that's
8 typically prescribed; right?

9 A. Right.

10 Q. You've never prescribed
11 cross-sex hormones for treatment of
12 gender dysphoria to anyone; correct?

13 A. Correct.

14 Q. You have no firsthand experience
15 with advising your patients about
16 potential risks and benefits of cross-sex
17 hormones when used for treatment of
18 gender dysphoria; correct?

19 A. Correct.

20 Q. You personally don't know what
21 doctors who do prescribe estrogen or
22 testosterone to their patients for gender
23 dysphoria tell those patients about the

1 risks and benefits of that treatment;
2 correct?

3 MR. KNEPPER: Objection, form.

4 A. I would answer that question as
5 we did earlier, that my expectation would
6 be that they would cover the -- the risks
7 and benefits of that -- of that
8 particular therapy and that the
9 exploration of potential risks would
10 include the major points that are
11 contained in the package insert and
12 whatever particular risks that the
13 patient may have because of their
14 underlying conditions, medical conditions
15 that may impinge upon them. That would
16 be my expectation.

17 Q. Okay. So for testosterone and
18 estrogen when used to treat gender
19 dysphoria, you would generally expect
20 doctors to at least give the warning
21 about -- that's in the labeling and
22 potentially give additional warnings
23 outside of that as well; fair?

1 MR. KNEPPER: Objection to form.

2 A. That would be my -- that would
3 be my expectation.

4 Q. All right. We started talking
5 about off-label use, so let's circle back
6 to that. So in your report, you
7 criticize Dr. Brown and Dr. Schechter for
8 not disclosing that the FDA has not
9 approved these hormones for treatment of
10 gender dysphoria. Do you recall that?

11 A. Yes. My testimony, yes, I do
12 recall that.

13 Q. All right. Off-label use is
14 when a doctor prescribes a drug outside
15 of its FDA-approved indication; correct?

16 A. Correct.

17 Q. And we touched earlier on
18 whether it's proper or improper to
19 prescribe drugs on an off-label basis.
20 There are circumstances where it is
21 appropriate to prescribe a drug on an
22 off-label basis; correct?

23 A. Yes.

1 Q. It's a case-by-case decision;
2 right?

3 MR. KNEPPER: Objection, form.

4 A. Yes.

5 Q. It's a case-by-case decision
6 that's made between the doctor and their
7 patient; right?

8 MR. KNEPPER: Objection, form.

9 A. Right.

10 Q. You're not expressing the
11 opinion that doctors should not be
12 prescribing drugs on an off-label basis
13 ever; right?

14 A. I'm expressing the opinion that
15 -- that drugs that have massive potential
16 side effects should not be off-label
17 prescribed unless those risks warrant --
18 I mean, those risks are warranted given
19 the underlying condition of the patient
20 and that the patient is being treated as
21 a -- as a -- as a trial or an
22 experimental patient with ethics
23 monitoring and all the rest of it that

1 attends.

2 The reason why off-label use is
3 problematic is because it doesn't have a
4 body of proven scientific evidence that
5 the FDA has made use of in order to -- to
6 warrant the use of the drug. So if
7 you're going to go off label, again, the
8 risks have to be low. If the condition
9 you're treating makes -- makes the risks
10 high, then that's where you have to get
11 into ethics panels and experimental
12 trials and things like that. I think
13 that's at the heart of this issue.

14 We're dealing with a condition
15 where the application of these drugs is
16 not proven and the risks are very high,
17 and that's where my concern lay.

18 Q. Do you think that off-label use
19 of prescription drugs is, by definition,
20 investigational?

21 A. To the extent that very often
22 the -- the use of -- the off-label use of
23 drugs begins on the basis of anecdotal

1 reports. So anecdotal reports, again,
2 are categorized as level 5 evidence. And
3 -- and so when those reports are
4 published and -- and the risks are seen
5 as low, then other physicians may begin
6 the off-label use of those drugs.

7 But generally, one wants to
8 progress to a more definitive scientific
9 evidence, like level 4 evidence where
10 there's a pre-application test, the use
11 of the drug, and a post-application test,
12 or level 3 where you're looking at
13 longitudinal data to confirm not only the
14 safety but the efficacy of the
15 application of the drug.

16 In the case of the use of
17 puberty blockade and cross-sex hormones,
18 it doesn't exist beyond level 5 evidence
19 even though the treatment has now been
20 going on off-label for more than a
21 decade, if not approaching twenty years.

22 Q. All right. You mentioned
23 doctors are prescribing on an off-label

1 basis after there's case reports. It
2 does happen that doctors prescribe drugs
3 on an off-label basis based on nothing
4 more than case reports; right?

5 A. That's how it always begins,
6 yeah.

7 Q. Yeah. The FDA doesn't say
8 that's not permissible, do they?

9 A. No, they don't.

10 Q. Okay.

11 A. I don't know. I don't know what
12 the FDA -- if there's a published policy
13 about that. I would suspect not, given
14 the history in my lifetime of people
15 off-label using, for example, asthma
16 medications for the treatment of breast
17 implant encapsulation, that kind of
18 stuff. That's an example of a very
19 benign drug being used off-label to treat
20 a surgical condition of breast implant
21 encapsulation. So that's my personal
22 experience. I suspect there isn't an FDA
23 policy that utterly prohibits it. I

1 would agree, yeah.

2 Q. Okay. The FDA is the federal
3 agency that regulates prescription drugs;
4 correct?

5 A. Food and drugs, yes.

6 Q. And they decide whether a
7 particular drug can be marketed for a
8 particular indication; correct?

9 A. Right.

10 MR. KNEPPER: Form.

11 Q. And one of the areas of
12 oversight the FDA has is the safety of
13 prescription drugs; right?

14 A. Right.

15 Q. Before forming your opinions in
16 this case, did you investigate what
17 position the FDA takes on off-label use
18 of drugs?

19 A. No, I did not.

20 Q. Sitting here today, do you know
21 what that position is?

22 A. I do not, no.

23 Q. Do you know whether the expert

1 opinions you're expressing about
2 off-label use of drugs are consistent or
3 inconsistent with what the -- what the
4 FDA has said about off-label use?

5 MR. KNEPPER: Objection, form.

6 A. I remember when the controversy
7 about the use of Singulair in breast
8 implant capsules came up. That was
9 discussed at an ASPS meeting and then
10 some articles that came out. And I think
11 I recall from those -- either the
12 conference or the article that the FDA
13 takes a permissive attitude where risk is
14 low.

15 Q. You think the FDA only allows
16 off-label use of prescription drugs when
17 the risk is low?

18 A. I don't know that for a fact.

19 Q. All right.

20 A. I would -- I would hope. I
21 would hope low risk/high benefit. So --
22 so again, it's an equation, it's not just
23 a one-sided thing. So it isn't just the

1 risk but also the potential benefits.
2 And the potential benefits have to be
3 very high. The higher the risk is, the
4 higher the benefit has to be. And that's
5 kind of a general principle of the
6 medical care. You know, before all else,
7 do no harm. That's what informs all
8 medical care, and I would hope that's
9 what informs the FDA policy, whatever
10 that may be.

11 Q. Okay. Well, let's look at the
12 policy.

13 A. Okay.

14 Q. I'm going to introduce another
15 exhibit. Okay. This is going to be
16 Exhibit 11. Let me know when you have
17 it.

18 (Exhibit 11 was marked for identification
19 and is attached.)

20 A. Okay.

21 Q. Have you ever seen this document
22 before?

23 A. I have not.

1 Q. Do you know what the Federal
2 Register is?

3 A. It's a -- it's a federal list of
4 regulations pertaining to things like
5 this.

6 Q. Yeah. It's the
7 official publication --

8 A. Federal code.

9 Q. -- of federal rules, proposed
10 rules, and notices for federal agencies;
11 right?

12 A. Yeah. Right.

13 Q. I see this is dated at the top
14 November 18, 1994. See that?

15 A. Yes.

16 Q. Page 1, middle column, see it
17 says, "Agency: Food and Drug
18 Administration, HHS"?

19 A. Let's see. "Agency: Food and
20 Drug Administration, HHS." Yes.

21 Q. It says, "Action." It says,
22 "Notice; request for comments." Do you
23 see that?

1 A. Yes.

2 Q. All right. Go to page 2.

3 A. Okay.

4 Q. In the column all the way to the
5 right, you see there's a section II, and
6 it's titled, "FDA Policy on Promotion of
7 Unapproved Uses." Do you see that?

8 A. I do.

9 Q. All right. The first paragraph
10 says, "Over a decade ago, the FDA Drug
11 Bulletin informed the medical community
12 that 'once a [drug] product had been
13 approved for marketing, a physician may
14 prescribe it for uses or in treatment
15 regimens of patient populations that are
16 not included in approved labeling.'" Do
17 you see that?

18 A. I do.

19 Q. What do you understand that to
20 mean?

21 A. That --

22 MR. KNEPPER: Objection.

23 A. I apply that to mean that --

1 that the -- that the FDA does not -- does
2 not intend to weigh in on off-label use,
3 you know, without restriction, I guess.
4 The sense I get of it is that they're --
5 they're declining to prohibit the
6 off-label use in -- in other patients at
7 this time, I would -- I would guess. I
8 suppose that if they started to see
9 complications, they might weigh in. This
10 has been the history, for example, with
11 nausea medicines and things like that
12 that created problems after use.

13 Q. At that time at least, the FDA
14 was telling the medical community that
15 doctors may prescribe drugs for uses
16 outside of FDA-approved indications;
17 correct?

A. Yes. I would say that --

19 MR. KNEPPER: Objection, form.

20 A. -- in 1994, the FDA declined to
21 -- to -- I don't know what they've done
22 subsequently. I -- but -- but in 1994,
23 they -- they -- off-label use was not

1 prohibited.

2 Q. Well, actually --

3 A. They finally --

4 Q. Sorry, finish.

5 A. No, go ahead.

6 Q. Well, you see this actually
7 says, "The publication further stated,"
8 and then there's a quote. And after the
9 quote, there's a Footnote 4.

10 Before we get to that, do you
11 see it says -- it cites to the FDA Drug
12 Bulletin from 1982.

13 A. Right.

14 Q. Right?

15 A. Right.

16 Q. So that original guidance came
17 from a 1982 FDA position; right?

18 A. Right.

19 MR. KNEPPER: Objection, form.

20 Q. And you say that you read this
21 and you don't think that the FDA has
22 taken a position, but let's see what else
23 that quote says. You see the quoted

1 language starting with "The publication
2 further stated"? Do you see that?

3 A. That starts with the word
4 "unapproved"?

5 Q. Yeah. It says, "'unapproved'
6 or, more precisely, 'unlabeled' uses may
7 be appropriate and rational in certain
8 circumstances, and may, in fact reflect
9 approaches to drug therapy that have been
10 extensively reported in medical
11 literature." Do you see that?

12 A. I do.

13 Q. You understand what that means;
14 right?

15 MR. KNEPPER: Objection to form.

16 A. Yes. Yes.

17 Q. Off-label use -- strike that.

18 The FDA has recognized as early
19 as 1982 that off-label use may be based
20 on medical literature, not published
21 indications; right?

22 A. Right.

23 Q. And then it says, "Valid new

1 uses for drugs already on the market are
2 often first discovered through
3 serendipitous observations and
4 therapeutic innovations, subsequently
5 confirmed by well-planned and executed
6 clinical investigations." Right?

7 A. Yeah. That's -- that's kind of
8 a -- just a restating of what I related
9 to you about, for example, the use of
10 Botox and hyperhidrosis, as I have done.
11 Yeah, I would totally agree with that.

12 Q. And then it says, "The agency
13 and its representatives have restated
14 this policy on numerous occasions." Do
15 you see that?

16 A. I do.

17 Q. Do you understand that for
18 decades, for three decades at least, the
19 FDA has taken the position that
20 physicians are allowed to prescribe drugs
21 on an off-label basis?

22 MR. KNEPPER: Objection, form.

23 A. Yes.

1 Q. Your report doesn't acknowledge
2 this longstanding position from the FDA,
3 does it?

4 A. My report does not -- no, it
5 does not.

6 Q. And I mean, I know I just heard
7 you say, well, maybe this is from the
8 '80s. Let me show you what the FDA says
9 today.

10 A. Okay.

11 Q. I'm going to introduce another
12 exhibit. This is Exhibit 12. Let me
13 know when you get it.

14 (Exhibit 12 was marked for identification
15 and is attached.)

16 A. Okay. All right. I've got it.

17 Q. All right. You see that this is
18 a printout from fda.gov, the official
19 website of the FDA; right?

20 A. Right.

21 Q. The title is "Understanding
22 Unapproved Use of Approved Drugs 'Off
23 Label.'" Right?

1 A. Right.

2 Q. Go to page 2.

3 A. Okay.

4 Q. Toward the bottom, it says in
5 bold, "Why might an approved drug be used
6 for an unapproved use?" Do you see that?

7 A. I do.

8 Q. Then it says, "From the FDA
9 perspective, once the FDA approves a
10 drug, healthcare providers generally may
11 prescribe the drug for an unapproved use
12 when they judge that it is medically
13 appropriate for their patient." Do you
14 see that?

15 A. I do.

16 Q. And then skipping one sentence,
17 it says, "One reason is that there"
18 may -- "might not be an approved drug to
19 treat your disease or medical condition."
20 Right?

21 A. Right.

22 Q. So the FDA -- the position that
23 the FDA takes is off-label use may be

1 medically appropriate for patients;
2 right?

3 A. Right.

4 Q. That's a position they've taken
5 for thirty years plus; right?

6 A. Right.

7 MR. KNEPPER: Objection, form.

8 Q. All right. And we talked
9 earlier about, you know, is off-label use
10 experimental or investigational. Before
11 forming those opinions, did you look to
12 see what the FDA says on that point?

13 A. How the FDA classifies
14 experimental or investigational?

15 Q. Do you know what position the
16 FDA takes on whether off-label use is
17 considered investigational?

18 A. I don't know what their official
19 position is, no.

20 Q. All right. Let's look at that.
21 All right. This is going to be Exhibit
22 13. Let me know when you have it.

23 (Exhibit 13 was marked for identification

1 and is attached.)

2 A. I have it.

3 Q. This is a guidance document from
4 the FDA from 1998. Generally, are you
5 aware that the FDA issues guidance
6 documents?

7 A. Generally, yes, I am aware.

8 Q. Have you ever seen an FDA
9 guidance document before today?

10 A. I've heard them referred to, but
11 I've never read one, no.

12 Q. Okay. All right. Well, this
13 one's titled "'Off-Label' and
14 Investigational Use of Marketed Drugs,
15 Biologics, and Medical Devices." You see
16 that?

17 A. I do.

18 Q. Okay. All right. The first
19 paragraph, second sentence says, "If
20 physicians use a product for an
21 indication not in the approved labeling,
22 they have the responsibility to be well
23 informed about the product, to base its

1 use on firm scientific rationale and on
2 sound medical evidence, and to maintain
3 records of the product's use and
4 effects." You see that?

5 A. I do.

6 Q. All right. The next sentence
7 says, "Use of a marketed product in this
8 manner when the intent is the 'practice
9 of medicine' does not require the
10 submission of an Investigational New Drug
11 Application, Investigational Device
12 Exemption or review by an Institutional
13 Review Board." Do you see that?

14 A. I do.

15 Q. I understand that what this is
16 saying, according to the FDA, when a
17 doctor prescribes a drug on an off-label
18 basis, that is not necessarily an
19 investigational use of that drug; right?

20 MR. KNEPPER: Objection, form.

21 A. I would disagree, because as it
22 says there, when they're -- when they're
23 prescribing in that manner, they have a

1 responsibility not only to be informed
2 about the product but to do the
3 recordkeeping of its effects, which is
4 really the initial phase of
5 investigation. So in a sense, they are
6 -- they are part of the investigative
7 process now because a new application of
8 the medication has been proposed, and
9 safety and efficacy have -- have to be
10 documented in some measure.

11 So the FDA is giving you room to
12 broaden the application of the drug, but
13 they're also placing upon you the burden
14 of documenting so that its effects and
15 benefits can be characterized because
16 that's being -- obviously, it's being
17 investigated. That's the point of their
18 wanting the recordkeeping, so --

19 Q. Do you know what the
20 Institutional Review Board is?

21 A. Yes.

22 Q. Clinical trials have to be
23 cleared by IR- -- IRBs; right?

1 A. Right.

2 Q. And this says you don't actually
3 have to apply for approval by an IRB when
4 you're prescribing a drug on an off-label
5 basis; right?

6 MR. KNEPPER: Objection, form.

7 A. It says that it's not of
8 necessity, so they're not making a
9 blanket requirement. I would imagine
10 that that might be modified in particular
11 cases.

12 Q. Yeah. Because this is saying
13 that when you're prescribing a drug on an
14 off-label basis, that doesn't mean you're
15 starting up a clinical trial; right?

16 A. It doesn't necessarily mean
17 you're starting a clinical trial, that's
18 right. It doesn't exclude the necessity
19 for a clinical trial. It just says
20 you're not necessarily starting a
21 clinical trial.

22 Q. Yeah. And when this says --
23 when it says doctors should maintain

1 records of the product's use and effects,
2 it's not telling them that they're
3 enrolling their patients in a clinical
4 trial by starting -- by prescribing a
5 drug on an off-label basis; right?

6 MR. KNEPPER: Objection, form.

7 A. Right. But what it -- what it
8 probably is inferring is that if they
9 start seeing complications, then the
10 further application of the drug in that
11 circumstance might be required -- might
12 require an IRB. So yeah. So it's --
13 what they're saying is it doesn't require
14 an IRB of necessity. It does require
15 recordkeeping. And I would expect that
16 if they were to see complications,
17 problems, lack of efficacy, that -- and
18 the desire for its continued use might
19 require an IRB. In fact, I would -- I
20 would hope it would require an IRB.
21 Yeah.

22 Q. Yeah. A clinical trial down the
23 line is a "this might be nice to have,"

1 but it's not a requirement for a doctor
2 to prescribe a drug on an off-label use
3 basis. That's what this says; right?

4 MR. KNEPPER: Objection, form.

5 A. That's what that says, yeah.

6 Q. Yeah. You don't cite this
7 guidance in your report obviously; right?

8 A. I don't think it's --

9 MR. KNEPPER: Objection, form.

10 A. I don't think it's germane to my
11 report. No.

12 Q. All right. You've also offered
13 opinions on whether it's proper to
14 prescribe drugs on an off-label basis to
15 children and adolescents; right?

16 A. I've only offered it in the case
17 of this particular therapy. I haven't
18 offered it generally, only in the case of
19 puberty blockade and cross-sex hormones
20 for the purposes of transitioning a child
21 to the appearance of the other sex.

22 That's all I've offered it as an opinion.

23 Q. All right. Do you know what the

1 American Pediatrics Association is?

2 A. Yes.

3 Q. Before forming your opinions,
4 did you look to see what the APA says
5 about off-label use of drugs in children
6 and adolescents?

7 A. No.

8 Q. Sitting here today, you don't
9 know the APA's position on this -- on
10 this topic; correct?

11 MR. KNEPPER: Objection, form.

12 A. Correct.

13 Q. Let's look at that next. Okay.
14 This is going to be Exhibit 14, and let
15 me know when you have it.

16 (Exhibit 14 was marked for identification
17 and is attached.)

18 A. Okay. I have it.

19 Q. You understand this is a policy
20 statement from the APA?

21 A. I'm reading it now. I see that
22 it is a policy statement from the
23 American Academy of Pediatrics.

1 Q. It's a policy statement
2 entitled, "Off-Label Use of Drugs in
3 Children." Right?
4

5 A. Yes. Yes.
6

7 Q. Look at the introduction section
8 toward the bottom of the page.
9

10 A. Okay.
11

12 Q. It says that, "The purpose of
13 this statement is to further define and
14 discuss the status of off-label use of
15 medic- -- medications in children." And
16 then it talks about a publication of a
17 2002 statement. You see that?
18

19 A. Yes.
20

21 Q. All right. So the FDA -- APA
22 has taken a position on off-label use of
23 drugs in children since at least 2002;
right?

24 MR. KNEPPER: Objection, form.
25

26 A. I'm reading it now. It appears
27 to be that, yeah.
28

29 Q. All right. Look at the abstract
30 towards the top.
31

1 A. Okay.

2 Q. Second sentence says, "However,
3 off-label drug use remains an important
4 public health issue for infants,"
5 childrens, and" -- "children, and
6 adolescents, because an overwhelming
7 number of drugs still have no information
8 in the labeling for use in pediatrics."
9 Do you see that?

10 A. I do.

11 Q. Okay. And then it says, "The
12 purpose of off-label use is to benefit
13 the individual patient." Right?

14 A. Yes.

15 Q. And then it says, "Practitioners
16 use their professional judgment to
17 determine these uses." Correct?

18 A. Yes.

19 Q. And then it says, "As such, the
20 term 'off-label' does not imply an
21 improper, illegal, contraindicated, or
22 investigational use." Right?

23 A. That's what it says there, yes.

1 Q. Yeah. The APA also takes the
2 position that off-label use does not
3 imply investigational use; correct?

4 MR. KNEPPER: Objection to form.

5 A. It does not de facto imply
6 off-label use, that's right, yeah. It
7 does not imply, right.

8 Q. And it does not imply that
9 off-label use is de facto improper or
10 illegal or contraindicated; right?

11 A. Right.

12 MR. KNEPPER: Objection, form.

13 Q. All right. Go to page 2.

14 A. Okay.

15 Q. Look at the left column, the
16 very bottom paragraph.

17 A. Okay.

18 Q. It says: "The absence of
19 labeling for a specific age group or for
20 a specific disorder does not necessarily
21 mean that the drug's use is improper for
22 that age or disorder. Rather, it only
23 means that the evidence required by law

1 to allow inclusion in the label has not
2 been approved by the FDA. Additionally,
3 in no way does a lack of labeling signify
4 that therapy is unsupported by clinical
5 experience or data in children."

6 Do you see that?

7 A. I do.

8 Q. This is the APA recognizing that
9 even in the absence of FDA approval for a
10 particular indication, that use may still
11 be supported by clinical experience and
12 data; right?

13 MR. KNEPPER: Objection, form.

14 A. Yeah. I would -- I would say
15 also that the APA recognizes that -- that
16 there's a poverty of evidence. The
17 poverty of evidence is one of the
18 characteristics of off-label use. And
19 that's -- that's what the nature of my
20 expert opinion was about, that the
21 poverty of evidence is what makes the
22 off-label use an issue, and in this case,
23 poverty of evidence for off-label use in

1 a situation where the harms -- potential
2 harms are great. That's what the concern
3 was, not -- obviously, I use -- I've
4 off-label used drugs in my own practice,
5 as I said before.

6 I don't have an objection
7 without qualification that -- that the
8 off-label use of drugs is somehow a
9 crime. I'm saying that in this
10 particular instance of this particular
11 application, that the off-label use tells
12 us that there's a poverty of scientific
13 evidence to support its application that
14 way. Clearly, there's anecdotal reports;
15 otherwise, doctors wouldn't be using it.
16 But there's a poverty of evidence, and
17 what we're dealing with here is not a
18 potential trivial complication but
19 potentially permanently life-altering
20 complications.

21 That was the issue that I was
22 addressing in my concern about the
23 off-label use, that there's a standard

1 of -- of caution that's required when you
2 go off-label. And that caution isn't
3 being demonstrated by the -- for the
4 persons who are prescribing or applying
5 these drugs in this way. That was my
6 concern.

7 Q. All right. You think that
8 before these drugs are to be prescribed,
9 they should first be supported by results
10 from clinical trials; right?

11 MR. KNEPPER: Objection, form.

12 A. That's the beginning.

13 Q. That's the beginning.

14 A. Yeah.

15 Q. The absolute minimum to
16 prescribe these drugs; right?

17 MR. KNEPPER: Objection, form.

18 A. Well, no. No, I -- I didn't say
19 that. As I said, it begins with
20 anecdotal evidence, not clinical trials.
21 So somebody somewhere sees an effect. As
22 it said in that FDA document, it's
23 oftentimes serendipitous. A clinician

1 will see an effect, and then -- and then
2 they'll, based on that, they'll hopefully
3 check out the potential risks to the
4 patient and then begin that off-label
5 use.

6 So it begins actually with
7 anecdotal reports, maybe case
8 collections, maybe a number of providers'
9 case collections, maybe it's a -- it's
10 a -- it's an institutional experience.
11 But that leads to clinical trials and the
12 IRB and all the rest of it. So that's
13 just the beginning of it.

14 Q. It may be appropriate for a
15 doctor to prescribe a drug on an
16 off-label basis without having the
17 results from a clinical trial; correct?

18 A. Yeah, I would -- I would hope
19 that after thirty years of doing this,
20 that we would beyond -- be beyond
21 institutional or personal experience,
22 that those trials would have already been
23 done. This isn't -- we're not just at

1 the beginning of puberty blockade and
2 cross-sex hormones. We're well into this
3 now, to the point where the European
4 literature is now vehemently rejecting
5 that.

6 That's -- these things have
7 changed. In the last three years, it's
8 all changed. With respect to this
9 off-label application of puberty blockade
10 and cross-sex hormones, it's changed
11 utterly. So these general statements
12 about off-label use are important to
13 understand, certainly, when you see a
14 serendipitous result and you consider
15 applying the drug. But we are so far
16 beyond that at this point in the history
17 of transgender therapy, this is where
18 we're concerned. We're concerned with
19 the continued off-label use, the
20 continued absence of clinical trials. We
21 should have been beyond that years ago.
22 And this is what the European literature
23 is now showing us, that the application

1 of those drugs by -- which is approved by
2 the APA, is now being rejected by the
3 medical services in Great Britain, in
4 Sweden, in Finland, in Holland. And this
5 is where we as American providers have to
6 get.

7 Q. All right. We'll -- we'll
8 definitely come back to those --

9 A. Okay.

10 Q. -- studies. I promise.

11 A. Okay.

12 Q. Let's finish this document
13 first, though. All right. Go to page 3.
14 All right.

15 A. Okay.

16 Q. Look at the left column.

17 A. Okay.

18 Q. It says: "Therapeutic
19 decision-making should always be guided
20 by the best available evidence and the
21 importance of the benefit for the
22 individual patient. Practitioners are in
23 agreement regarding the importance of

1 practicing evidence-based medicine.
2 However, for the pediatric population,
3 gold standard clinical trials are often
4 not available, so practitioners must rely
5 on either less definitive information,
6 such as expert opinion for the age group
7 that they are treating, or use evidence
8 from a different population to guide
9 practice."

10 You see that?

11 A. I do. And I would agree with
12 that, that particularly in pediatric
13 patients, the clinical trial approach
14 oftentimes is -- is not available because
15 of the nature of the condition and so on.
16 But in the -- in this case, there's a --
17 it's not an all or none, it's got to be
18 clinical trials or -- or nothing.

19 There's longitudinal
20 population-based studies, long-term
21 results seen in a population that has
22 matured through this therapy, and looking
23 at, you know, cohort studies

1 longitudinally, cohort study, which is --
2 which is an alternative when -- when the
3 clinical trial is not available to you
4 for ethical reasons. Like you wouldn't
5 do sham surgery on somebody. That would
6 be ethically untenable. But you can look
7 at population-based studies where you
8 have a cohort to compare. And that's --
9 that's where we should be. That's where
10 the European literature is now.

11 So I would agree with that
12 statement that -- that the APA is making
13 there, but I would qualify it by saying
14 that there's an alternative available
15 that brings you to a higher level of
16 evidence that may in fact bring it to
17 on-label use if they were to bother to do
18 it.

19 Q. The APA recognizes that for the
20 pediatric population in particular,
21 results from clinical trials are often
22 not available; right?

23 A. Right.

1 Q. And the answer in those
2 situations is not to stop prescribing
3 these drugs altogether; right?

4 MR. KNEPPER: Objection, form.

5 A. Yeah. The "altogether" would be
6 the qualifier there because there are
7 some circumstances where it would be -- I
8 mean, it wouldn't be good to stop its
9 prescription, but there would be others
10 that you would have to examine more
11 carefully because of the risk issue.

12 Q. Yeah. Instead, what the APA
13 says is that when clinical trial results
14 are not available, doctors have to rely
15 on less definitive -- definitive
16 information; right?

17 A. That's what -- that's all you
18 have. That's right.

19 Q. Yeah. The APA says it may be
20 appropriate for doctors to prescribe
21 drugs to pediatric patients on an
22 off-label basis even when that use is not
23 supported by randomized clinical trials;

1 correct?

2 A. Right.

3 Q. Because the reality is that for
4 a lot of conditions, in the pediatric
5 population, there are no randomized
6 clinical trial results available; right?

7 MR. KNEPPER: Objection, form.

8 A. Again, so you're holding out
9 randomized clinical trial, or they're
10 holding out randomized clinical trial as
11 the only alternative to the lowest form
12 of evidence. And I -- I agree that
13 randomized clinical trial are not always
14 available, and we have to have recourse
15 to perhaps lesser but nonetheless more
16 convincing forms of evidence to fall back
17 on rather than falling back to the lowest
18 form of evidence as is the case today
19 with the application of these drugs.

20 Q. All right. Look at the last
21 paragraph in the left column of this
22 page.

23 A. Okay.

1 Q. It says: "In most situations,
2 off-label use of medications is neither
3 experimentation nor research. The
4 administration of an approved drug for a
5 use that is not approved by the FDA is
6 not considered research and does not
7 warrant special consent or review if it
8 is deemed to be in the individual
9 patient's best interest." Do you see
10 that?

11 A. I do.

12 Q. If the physician deems an
13 off-label use to be in the individual
14 patient's best interest, that's not
15 experimental use, according to the APA;
16 right?

17 MR. KNEPPER: Object to the
18 form.

19 A. Well, according to the --
20 according to the APA, in most situations.

21 Q. Yeah.

22 A. So in that statement, it
23 acknowledges that there are some

1 situations where that would be
2 considered. That's the implication in
3 that statement. So "most" is the
4 qualifier, implying that there are
5 situations where it would be considered
6 experimental.

7 Q. Okay.

8 A. And that's what we propose in
9 our expert testimony, is that this is one
10 of those situations. This is
11 experimental use.

12 MR. TISHYEVICH: Now let's go
13 off the record.

14 THE VIDEOGRAPHER: This is the
15 end of Media Unit No. 3. We are off the
16 record at 12:30 p.m.

17 (Break taken.)

18 THE VIDEOGRAPHER: This is the
19 start of Media Unit No. 4. We are on the
20 record at 1:21 p.m.

21 Q. (By Mr. Tishyevich) All right,
22 Doctor. You know you're still under
23 oath; right?

1 A. Yes.

2 Q. Before lunch, we were talking
3 about off-label use of prescription
4 drugs. Do you know how common or
5 uncommon off-label use of prescription
6 drugs is in the overall population?

7 A. I'm not familiar with that
8 number, no.

9 Q. All right. You don't know if
10 it's 5 percent or 10 percent or 50
11 percent of all drugs are prescribed off
12 label; right?

13 A. I have no idea.

14 Q. How about pediatrics
15 specifically? Do you know how common or
16 uncommon off-label use is in the
17 pediatric population?

18 A. I do not.

19 Q. Let me introduce an exhibit.

20 MR. KNEPPER: One second.

21 Dr. Lappert?

22 THE WITNESS: Yes.

23 MR. KNEPPER: Your camera has

1 moved accidentally, yeah.

2 THE WITNESS: It just allows me
3 to look at the bottom of the other screen
4 here so I can look at the exhibits.

5 MR. KNEPPER: Okay. I think
6 just for the video recording, we want to
7 make sure that the camera stays on your
8 face.

9 THE WITNESS: I'll go like this,
10 then.

11 MR. KNEPPER: Perfect.

12 Q. (By Mr. Tishyevich) So this is
13 going to be Exhibit 15. Let me know when
14 you have it.

15 (Exhibit 15 was marked for identification
16 and is attached.)

17 A. All right. I have it.

18 Q. All right. This is a study from
19 2019 by Dr. Yackey, Y-A-C-K-E-Y, titled
20 "Off-label Medication Prescribing
21 Patterns in Pediatrics: An Update." Do
22 you see that?

23 A. I do.

1 Q. All right. And the objective is
2 "To describe the frequency of off-label
3 drug use in 2014 as defined by the
4 FDA-approved age ranges in patients 18 or
5 under 18 years of age." Do you see that?

6 A. I do.

7 Q. All right. Look at "Methods."
8 Do you see that section?

9 A. I do.

10 Q. It says, "This is a
11 retrospective cohort study of an
12 administrative database containing
13 inpatient resource use data from January
14 1, 2014, to December 31, 2014." And do
15 you see that?

16 A. I do.

17 Q. Look at the "Results" section.

18 A. Okay.

19 Q. The first sentence says, "At
20 least 1 drug was prescribed off-label in
21 779,270 of 2,773,770 (28.1%) patient
22 visits during the study period." Do you
23 see that?

1 A. I do.

2 Q. And skipping a sentence, then it
3 says: "Off-label usage of certain
4 medications differed between care
5 settings. Rates of off-label medication
6 use were higher in observational (45.5%),
7 inpatient (53.9%), and ambulatory (54.2%)
8 settings." Do you see that?

9 A. I do.

10 Q. All right. The study concluded
11 after reviewing 2.7 patient visits that
12 overall, 28.1 percent of patients were
13 prescribed an off-label -- prescribed a
14 drug on an off-label basis; right?

15 A. Right.

16 Q. And depending on the setting,
17 off-label prescriptions in the pediatrics
18 context can be as high as 45 to 54
19 percent; right?

20 A. That's what the study shows.

21 Q. All right. The reality is that
22 prescribing drugs to children and
23 adolescents on an off-label basis is a

1 fairly common practice; right?

2 MR. KNEPPER: Objection to form.

3 A. It appears to be, yes.

4 Q. You did not know this before you
5 formed your expert opinions?

6 A. I knew that it was more common
7 in children than in adults, and I knew
8 that it was, you know, fairly common,
9 having -- having prescribed off-label
10 myself to children, that it's -- it's
11 probably fairly common. I didn't know
12 the exact numbers, though, until now.

13 Q. Okay.

14 A. Again, my -- my expert opinion
15 about this is not about does it happen.
16 It's about the particular case of the
17 transgendered person receiving an
18 off-label use of a -- of a fairly
19 problematic drug in light of the recently
20 changing evidence about its efficacy. So
21 the issue of off-label use that I
22 presented was not about are drugs
23 prescribed off-label. The issue was

1 these particular drugs in these
2 particular patients off-label in light of
3 the recent change in the world literature
4 about the risk/benefits of doing those
5 things. And the evidence now is that
6 that whole position about puberty
7 blockade and cross-sex hormones, it's
8 falling apart in the last three years,
9 and there's a -- there's a growing wave
10 of evidence that says do not do this.
11 And in fact, that's where the Court
12 stepped in in Great Britain, and it's
13 where the Karolinska Institute stepped
14 in.

15 It's not that it's off-label
16 use. It's that it's particularly
17 problematic in the case of these drugs in
18 these suffering patients. That's what my
19 expert opinion was about. It was not
20 about drug policy. It was about these
21 patients, these problems, these drugs.
22 And the fact is that when you off-label
23 use, the responsibility falls much more

1 heavily on the provider. When the FDA
2 approves it, the responsibility falls to
3 the shoulders of the approving authority.
4 But if you're going off-label, it's on
5 you as the provider to be certain that
6 you're doing good to the patient. And up
7 until the last three years, the evidence
8 wasn't there. Now it's there. The
9 continued use of the drugs in this way
10 has become very problematic, and that's
11 -- that's what my expert opinion was
12 about, not about drug policy, but about
13 these drugs, these patients.

14 Q. Doctor, there's actually no
15 question pending, so I'm going to ask
16 that you stick with listening to my
17 questions and then answering them instead
18 of making speeches. Okay?

19 All right. You -- we talked
20 earlier about the Botox injections that
21 you've done; right?

22 A. Yes.

23 Q. You told me you've been doing

1 Botox injections in the forehead for over
2 ten years; right?

3 A. Correct.

4 Q. You've told me that you've been
5 doing Botox injections for crow's feet
6 for over ten years; right?

7 A. Yes.

8 Q. Do you know when the FDA first
9 approved Botox for the use of treating
10 forehead wrinkles?

11 A. Let's see. I recall that it was
12 when I was the chief of plastics at
13 Portsmouth, Virginia, because we had been
14 using it for dystonias and things like
15 that in children. And it got approved
16 for cosmetic use I'm going to say before
17 we moved to the new hospital, so it had
18 to have been around ninety- -- I want to
19 say '97, somewhere in there. I'm just
20 ballparking it here.

21 Q. So when you were using Botox to
22 do forehead injections, you think that
23 was an on-label FDA approved use for the

1 last ten years; right?

2 A. Yeah. When used in the
3 corrugator and procerus muscles, that's
4 the on-label use for cosmetic botulinum
5 toxin.

6 Q. Let me introduce another
7 exhibit. All right. This is going to be
8 Exhibit 16, and let me know when you have
9 it.

10 (Exhibit 16 was marked for identification
11 and is attached.)

12 A. All right. I have it.

13 Q. Top right corner, you see it
14 says, "Food and Drug Administration"?

15 A. Yes.

16 Q. Below that, do you see it says,
17 "Supplement Approval"?

18 A. Yes.

19 Q. You know what this is?

20 A. It looks to be a -- a letter
21 from the FDA to the Allergan corporation,
22 to a particular Ph.D. there who is the
23 director of regulatory affairs. And it's

1 a supplemental -- I guess it's an
2 amendment. I haven't read it. Can I
3 have a moment to read it?

4 Q. I'll -- I'll point you to it.
5 Don't worry.

6 A. All right.

7 Q. Allergan is a manufacturer of
8 Botox; right?

9 A. Allergan, yes, uh-huh.

10 Q. Go to page 3.

11 A. Okay.

12 Q. And you see there's a signature
13 line, and under that, it says,
14 "10/02/2017"?

15 A. Correct.

16 Q. You understand this was issued
17 on October 2, 2017; right?

18 A. That's -- that's what the
19 document appears to show, yeah.

20 Q. Go back to the first page.

21 A. Okay.

22 Q. First paragraph says, "Dear Dr.
23 Richmond: Please refer to your

1 Supplemental Biologics License
2 Application, dated and received December
3 , 2016." Do you see that?

4 A. I do.

5 Q. The next paragraph says, "This
6 Prior Approval supplemental biologics
7 application proposes an additional
8 indication for the temporary improvement
9 in the appearance of moderate to severe
10 forehead lines associated with frontalis
11 muscle activity."

12 A. Right.

13 Q. Do you see that?

14 A. I do.

15 Q. All right. Then the next
16 section says, "Approval & Labeling."
17 Right?

18 A. Yes.

19 Q. It says, "We have completed our
20 review of this supplemental application,
21 as amended. It is approved, effective on
22 the date of this letter, for use as
23 recommended in the enclosed, agreed-upon

1 labeling text." Do you see that?

2 A. I do.

3 Q. All right. You understand that
4 Botox was not an FDA-approved treatment
5 for improvement in moderate to severe
6 forehead lines until October 3, 2017 --

7 MR. KNEPPER: Objection --

8 Q. -- right?

9 MR. KNEPPER: -- to form.

10 A. The sense I get of your question
11 is that you -- you're conflating the
12 injection of corrugator and procerus
13 muscles with the injection of the
14 frontalis muscles. I consider all those
15 muscle groups to be forehead muscles
16 because they all animate the brow. The
17 approval of Botox for the corrugator and
18 frontalis -- I mean, corrugator and
19 procerus muscle that goes way back is, I
20 thought, what you were -- you were asking
21 me about with ten years application to
22 the forehead. So yeah. So I consider
23 the -- the corrugator and procerus

1 muscles (indicating) forehead muscles.
2 Maybe others would call them glabellar,
3 but glabellar is the lesser-included
4 category. So yeah.

5 So I was aware of the broadened
6 application, and I was aware that for
7 most of the time it's been on the market,
8 it has been limited, the approval been
9 limited to the corrugator and procerus.
10 And the frontalis marginal radicularis
11 was considered off-label use, as was its
12 use in hyperhidrosis, like we talked
13 about earlier. Yeah.

14 Q. You have prescribed Botox
15 cosmetic -- or strike that.

16 You have used Botox for
17 treatment of moderate to severe forehead
18 lines associated with frontalis muscle
19 activity before October 3, 2017; correct?

20 A. Yes.

21 MR. KNEPPER: Objection to form.

22 A. Absolutely.

23 Q. It's an off-label use; right?

1 A. As we've talked about before,
2 yes, I've -- I've used it off-label.

3 Q. And do you know when Botox
4 received this indication for treatment of
5 crow lines?

6 A. I'm sorry. Of?

7 Q. Treatment of crow lines.

8 A. Crow lines?

9 Q. Yes.

10 A. Oh, crow's feet (indicating).

11 Q. Sorry, crow's feet.

12 A. Yeah. Yeah. I don't know -- I
13 don't know the exact date of that. I
14 just know that it's been broadened.

15 Q. All right. Before -- strike
16 that.

17 Before you first started using
18 Botox on an off-label basis, did you do a
19 literature search to see if there was a
20 randomized, double-blinded controlled
21 trial to demonstrate that this forehead
22 use was safe and effective?

23 A. No.

1 MR. KNEPPER: Objection, form.

2 Q. So you were using it without
3 having any idea if there was randomized
4 controlled clinical trials to demonstrate
5 the safety and effectiveness of that use;
6 correct?

7 MR. KNEPPER: Objection, form.

8 A. So the question is, was I using
9 it in other than the on-label purposes
10 before the approval was handed down by --
11 to the -- by the FDA?

12 Q. No. I already heard the answer
13 to that question.

14 A. Oh, okay.

15 Q. I'm asking you a different
16 question.

17 A. Okay.

18 Q. At the time you were using
19 Botox on --

20 A. Oh.

21 Q. -- an off-label basis --

22 A. Right.

23 Q. -- you were doing that without

1 having results from a randomized
2 controlled trial to demonstrate that this
3 off-label use was safe and effective;
4 correct?

5 A. Correct. Correct.

6 MR. KNEPPER: Objection, form.

7 Q. The same is true for respective
8 cohort studies; right?

9 A. Correct.

10 Q. The same is true for case
11 control studies; right?

12 MR. KNEPPER: Objection, form.

13 A. Right. And that's an example of
14 what we were talking about earlier where
15 a low-risk application begins with
16 anecdotal experience, shared anecdotal
17 experience, and -- and the literature
18 that comes later leading to the
19 controlled trial that the Allergan
20 company may have done and it's then
21 subsequently approved by the FDA. That's
22 right. So this would fit into that
23 category.

1 Q. All right. Let's talk more
2 about randomized controlled trials
3 outside of Botox. If I call them RCTs
4 for short, you'll know what I'm referring
5 to; right?

6 A. Yes.

7 Q. An RCT typically involves two
8 groups, an experiment group and a control
9 group; right?

10 A. Yes.

11 Q. RCTs are typically
12 double-blinded; right?

13 A. Well, in most cases. But when
14 you're talking about things where there's
15 going to be an outward change in the
16 patient, it's -- it's difficult to blind
17 such studies. You're essentially just --
18 for example, you couldn't have a
19 double-blinded study of a surgical
20 procedure, or you couldn't have a
21 double-blinded study of a -- of a medical
22 intervention where there's outward change
23 to the patient that would be evident to

1 both the experimenter and the subject.

2 So yeah.

3 Q. Yeah. So -- yeah, we'll get to
4 that in a minute. Let me ask just some
5 more general questions first.

6 A. Okay.

7 Q. Because I want to figure out
8 your experience with RCTs. You
9 personally have never been the lead
10 investigator for an RCT; correct?

11 A. That's correct.

12 Q. You personally -- strike that.
13 Have you ever been involved with
14 an RCT?

15 A. Yes. When I was a resident at
16 the University of California-San
17 Francisco working on the neurosurgical
18 trauma unit, we were doing a randomized
19 controlled trial of the medical
20 management of elevated intracranial
21 pressure, and I was -- because I was part
22 of the team, I was responsible for
23 gathering data in the critical care unit

1 and -- and working with the investigators
2 ensuring the integrity of the data. So I
3 was not the lead investigator, obviously.
4 I was just one of the participants as one
5 of the treating physicians.

6 Q. The only time you worked on a
7 randomized controlled trial was during
8 your surgery res- -- general surgery
9 residency; correct?

10 MR. KNEPPER: Objection, form.

11 A. I'm trying to think if there
12 were other instances here. At UC-Davis
13 -- I'm trying to think. Give me just a
14 moment. I just want to --

15 Q. Sure.

16 A. -- make sure I'm not missing any
17 more. I think that's the only one where
18 it was a randomized blinded study.
19 That's right, yeah.

20 Q. And that residency was '87
21 through '91?

22 A. That's right.

23 Q. Okay. You've never published

1 any articles in peer-reviewed journals
2 about RCTs; correct?

3 A. That's correct.

4 Q. You've personally never designed
5 an RCT; correct?

6 A. That's correct.

7 Q. You don't hold yourself out as
8 an expert in RCT design; right?

9 MR. KNEPPER: Objection, form.

10 A. Well, I would qualify that
11 answer by saying that part of my training
12 involves me being able to understand and
13 review published literature on the
14 subject even though I'm not the
15 investigator because of my training as a
16 plastic and reconstructive surgeon, as a
17 general surgeon. As just a physician in
18 general, we're trained on how to
19 interpret the validity or the veracity of
20 the medical literature, including how to
21 interpret the randomized controlled trial
22 and -- and understand its validity, which
23 is -- what I'm testifying about is not my

1 personal experience. It's my opinion of
2 the validity of the scientific data. So
3 I -- so it's not that I -- that I can't
4 express an opinion on it. It's just that
5 I haven't personally conducted one, but I
6 have been trained on how to interpret
7 them.

8 Q. I understand that distinction
9 you're making.

10 A. Thank you.

11 Q. But when it comes to designing
12 RCT, you're not an expert in that aspect
13 of RCT?

14 MR. KNEPPER: Objection, form.

15 A. Well, again, part of the
16 evaluation of a randomized controlled
17 trial is to evaluate how the study was
18 designed. That's one of the criteria
19 used for understanding the validity of a
20 published document like a RCT. So you
21 always look at -- that's why it's such an
22 essential part of a -- of a RCT
23 publication is you look at the materials

1 and methods and you look at the study
2 design, and that's where, really, your
3 analysis begins if you're trying to
4 interpret the data. Did they design the
5 study properly? Does it have the power
6 of discrimination of what they claim that
7 it has? And then you look at the actual
8 results, and it's on -- it's on your
9 shoulders as the -- as the professional,
10 whether you're a -- you know, a
11 researcher or somebody who's seeking to
12 apply it in his practice, you're
13 responsible for interpreting the data
14 quite apart from their interpretation of
15 it.

16 So an example of that would be
17 the Branström study, where they --
18 they -- they generated a good -- a
19 reasonable study design, but they
20 misinterpreted the data, and that's what
21 caused the retraction of the Branström
22 study, is that all the other people who
23 were not RCT investigators, but they were

1 all physicians, endocrinologists,
2 pediatricians, they looked at the data
3 and said, "You've misinterpreted the
4 study."

5 And that's really what we're
6 talking about here. There are those who
7 perform the study, and then there's us
8 who have to live with it, and we have to
9 be able to understand what they're --
10 what they're purporting to. So we have
11 to interpret the data even before reading
12 their conclusions.

13 Q. Do you know what the CONSORT
14 criteria are? C-O-N-S-O-R-T.

15 A. I've read it sometime before. I
16 can't -- I can't -- I can't quote it for
17 you, but it's -- it's germane to the
18 study design process? I'm not sure.

19 Q. Okay. Can you describe for me
20 what the CONSORT criteria are in general
21 terms?

22 A. I cannot.

23 Q. All right. How about cohort

1 studies? You've personally never
2 designed a cohort study; correct?

3 A. No, I have not.

4 Q. You've personally never been an
5 investigator in a cohort study; correct?

6 A. Well, so -- so, that experience
7 at -- at UC-San Francisco was a -- well,
8 so are you asking -- by cohort study, are
9 you talking about like a retrospective
10 study of a -- of a population cohort? Is
11 that what you're asking me about?

12 Q. Prospective or retrospective,
13 either -- either/or.

14 A. I haven't designed any of those
15 studies, no.

16 Q. Okay. And outside the one
17 experience in your residency, have you
18 ever been involved with any prospective
19 or retrospective cohort study?

20 A. No.

21 Q. And how about case-control
22 studies? Have you ever personally
23 designed a case-control study?

1 A. No, I have not.

2 Q. Have you ever been an
3 investigator in a case-control study?

4 A. I'm just trying to think if the
5 -- if the head trauma investigation would
6 fit the category of a case control. It
7 was a randomized study. It had its own
8 internal controls. So I guess I've
9 assisted in that investigation, but only
10 as a -- as a provider and a -- and a data
11 gatherer.

12 Q. Outside of that one experience,
13 you have not been involved with any
14 prospective or retrospective cohort
15 study; right?

16 A. No.

17 Q. Or a case-control study? Excuse
18 me.

19 Okay. Let's go back to your
20 report, Exhibit 1, and go to page 13.

21 A. Okay. Okay.

22 Q. You see there's a header that
23 says in capital letters, "Anecdotal

1 Patient Stories Are Not Data." Do you
2 see that?

3 A. I do.

4 Q. And you write, "Drs Schechter
5 and Brown also failed to disclose and
6 properly discuss that Anecdotal Data
7 unverified patient reports without
8 control groups, randomized trials, or
9 other scientific protections for the
10 integrity of the medical system -- are
11 not reliable science." Do you see that?

12 A. I do.

13 Q. And then you reference personal
14 patient stories, and you say, "This is
15 unreliable Anecdotal Data and it is not
16 credible, scientific information." Do
17 you see that.

18 A. I do.

19 Q. All right. You think that case
20 reports are anecdotal evidence; right?

21 A. Yeah, they're --

22 MR. KNEPPER: Objection.

23 THE WITNESS: I'm sorry?

1 MR. KNEPPER: Objection, form.

2 Go ahead.

3 THE WITNESS: I'm sorry.

4 A. Yeah. And so anecdotal data is
5 personal experience of a -- of a
6 practitioner, for example. So -- so a
7 surgeon reporting on five cases that he
8 did would be considered anecdotal
9 reporting, or case reports and things
10 like that, yeah. That's anecdotal,
11 personal experience, a personal exper- --

12 Q. And you think --

13 A. I'm sorry?

14 Q. Go ahead. Sorry.

15 A. Personal experience as distinct
16 from more stringent scientific evidence
17 like a longitudinal study or a cohort
18 study or something like that. Or even --
19 even personal experience with pre- and
20 posttreatment testing rises to a higher
21 level than anecdotal. So you can base --
22 you can base scientific evidence on that
23 next level, which would be anecdotal

1 experience elevated to the next level by
2 pretreatment and posttreatment testing.
3 This is -- this is from the guidance that
4 the American Society of Plastic Surgery
5 puts out.

6 So depending on the -- depending
7 on the type of study, if it's a -- if
8 it's a therapeutic study or a diagnostic
9 study or a prognostic study, depending on
10 what you're looking at, if -- if you --
11 if you take it to that next level with
12 pre- and posttreatment testing with a
13 validated scientific instrument, you
14 know, a validated study even of
15 subjective reporting from the
16 psychiatric/psychological side of things,
17 that has more validity than the anecdotal
18 reports of a practitioner or even an
19 institution.

20 Q. Do you think that a case report
21 that doesn't have this before and after
22 comparator that you describe is
23 essentially worthless from the --

1 A. No.

2 Q. -- scientific perspective?

3 A. No, no. Not worthless. Not
4 worthless, but it's what's considered in
5 the -- in the -- in plastic surgery
6 circles, certainly, it's considered the
7 lowest form of evidence. So for a number
8 of years now, the American Society of
9 Plastic Surgery has insisted that
10 publications -- if you're going to
11 publish a case series, for example, that
12 they have to be a sequential -- you can't
13 pick the cases you're reporting on. It
14 has to be a sequential series of
15 patients, and you have to declare in the
16 publication, in your -- in your article,
17 the level of evidence that you're
18 presenting.

19 So if -- if it's merely a --
20 case reports, that would be level 5
21 evidence. If you added to that a review
22 of the literature with a -- you know, a
23 definitive review of the literature

1 looking at the -- at where the weight of
2 evidence lies, then you raise it to the
3 next level. But we're -- we're now
4 required when we're publishing in -- in
5 the ASPS journal, for example, to state
6 in the -- in the document level of
7 evidence. So a case report is not zero
8 scientific evidence. It's level 5
9 evidence. It's the lowest form of -- of
10 evidence is what it is.

11 Q. You personally would not rely on
12 a level 5 case report to decide if a
13 surgical technique is effective?

14 A. It would be the beginning of my
15 interest in a particular technique. As a
16 surgeon, we tend to be very conservative,
17 and we call upon our personal experience
18 very much and certainly upon our
19 training. So if somebody proposes
20 something radically new and all they have
21 to support it is level 5 evidence,
22 generally -- there's a saying that I
23 learned in training is never be the first

1 or -- first one to do a procedure or the
2 last one to do a procedure.

3 And so, yeah, you know, surgeons
4 tend to not jump in early on -- on
5 low-quality evidence. We tend to be
6 conservative about it. And I would
7 number myself among them.

8 Q. All right. Let me ask the flip
9 side.

10 A. Okay.

11 Q. Do you think it's necessary for
12 a surgical procedure to be supported by
13 results from a level 5 RCT before it can
14 be considered effective?

15 A. No.

16 MR. KNEPPER: Objection to form.

17 A. That would -- that would be one
18 of those circumstances where what is the
19 risk to the patient and -- and what's the
20 potential benefit to the patient.
21 That's -- that's what kind of would drive
22 my decision to act on a level 5 case
23 report, offering something like that to

1 one of my patients.

2 Q. Do you think that a surgical
3 procedure has to be supported by a level
4 2 controlled study before that surgical
5 procedure can be considered
6 nonexperimental?

7 A. Not necessarily. It would
8 depend on what is -- what is -- what is
9 at risk here. Certainly, we're much more
10 willing to -- to proceed with -- with
11 techniques and procedures that aren't
12 hugely supported if there's great risk to
13 the patient of not doing anything. So
14 level of risk and what is at stake kind
15 of drives that and -- and yeah.

16 Did I answer that question? Is
17 that what you were asking?

18 Q. Yeah. It's basically a
19 case-by-case decision; right?

20 MR. KNEPPER: Objection, form.

21 A. Well, I wouldn't say case by
22 case. I would say, you know, you're
23 relying on -- on -- on a lifetime of

1 experience possibly, and you're relying
2 also on -- on conversations with your
3 peers, your colleagues, what is their
4 experience in the area and how much of a
5 risk are you going to subject to the
6 patient -- subject the patient to in
7 order to achieve a result. The greater
8 the risk, the greater the expectation of
9 a defined scientifically supported
10 outcome.

11 So in the case -- in the issue
12 at hand here, great risk of doing, for
13 example, a transition surgery, because
14 you're talking about permanent
15 sterilization, irreversible
16 sterilization, or the removal of the
17 breasts, permanent and irreversible loss
18 of the breasts, that's a huge stake, a
19 huge risk to the patient that the -- the
20 expected outcomes have to be consummately
21 much larger in order to justify something
22 like that if you don't have scientific
23 support. If you're at low levels of

1 scientific evidence, then clearly, you
2 have an obligation to the patient not to
3 -- not to try something risky if you
4 don't have extensive and very valid
5 scientific -- and that's where we are
6 now. We're at very low-level evidence
7 for these things. That's kind of why
8 we're here today.

9 Q. I guess I'm asking a more
10 specific question. You're not taking the
11 position that in order to be considered
12 nonexperimental, a particular surgical
13 procedure has to be supported by at least
14 level 1 or level 2 evidence; right?

15 MR. KNEPPER: Objection, form.

16 A. Oh, okay. So you're asking me
17 the definition of experimental. Is
18 that -- do I understand you correctly?

19 Q. Sure.

20 A. Yes. Am I saying that something
21 is nonexperimental once it reaches level
22 2 evidence or higher and not before?

23 Q. Correct.

1 A. I'm not saying that, no.

2 Q. Okay. How about level 3? Are
3 you taking the position -- strike that.

4 Are you expressing the opinion
5 that a surgical procedure can only be
6 considered not experimental if it reaches
7 evidence level 3?

8 A. Well, it's getting closer. So
9 when you're -- when you're at level 3,
10 you're talking about a retrospective
11 study with a cohort. And if we were
12 talking about some simple technique of
13 reconstructing, say, a wound on the face
14 for cancer therapy, then I certainly
15 wouldn't wait to try a new technique. If
16 it promised to get a better result, I
17 wouldn't wait until I got to level 3
18 evidence.

19 But if you're talking about a
20 very drastic operation where I'm
21 amputating healthy parts, then yeah, I'm
22 going to want to go at least to level 3
23 before I consider that, because again,

1 you're talk about tremendous risk to the
2 patient, permanently life-altering
3 changes. You better have very strong
4 evidence that you're doing the patient
5 good because you're doing the patient a
6 great harm by, you know, removing their,
7 genitals, permanently sterilizing them,
8 removing their breasts. So again, it's
9 -- it's not a case by case, but let's --
10 let's say broad categories of -- of
11 techniques or surgery.

12 If you're talking about
13 something small like reconstructing a
14 facial defect, then yeah, you don't need
15 to get to level 3. But if you're talking
16 about something large and permanently
17 life-altering, then at least level 3.

18 Q. All right. We talked earlier a
19 while ago about some of the surgical
20 procedure you performed, and I think one
21 of the things you mentioned was breast
22 reductions.

23 A. Yes.

1 Q. Right?

2 A. Yes.

3 Q. You've done those; right?

4 A. I have done so many of those.

5 Q. All right. You've done breast
6 reduction surgery without having the
7 results from a randomized controlled
8 clinical trial; right?

9 A. I believe the -- the bulk of the
10 evidence in the therapeutic benefit of
11 breast reduction is primarily given to us
12 by a long-term longitudinal cohort study
13 that we actually get from the insurance
14 industry. Because when you do breast
15 reduction surgery, one of the key issues
16 in a breast reduction is, is it going to
17 be efficacious in curing an orthopedic
18 problem. So if you're talking about
19 breast reduction surgery as a quote,
20 unquote reconstructive procedure, then
21 really, it's being applied to an
22 orthopedic condition.

23 And the insurance companies have

1 a wealth of evidence about, for example,
2 the weight of the specimen that has to be
3 submitted in order to have a hope of
4 relieving the orthopedic complaint of
5 neck, back, and shoulder pain.

6 So -- and vir- -- and I can tell
7 you categorically, because I'm very
8 fastidious about this, that all of the
9 breast reduction operations that I've
10 ever done for the orthopedic condition of
11 neck, back, and shoulder pain have met
12 the criteria based upon this long-term
13 longitudinal cohort study that the
14 insurance companies have been running
15 since back in the '80s at least.

16 Q. All right. Doctor, again, I
17 need you to listen to my questions. I
18 didn't ask about cohort studies. I asked
19 about randomized clinical trial.

20 A. Oh.

21 Q. You have done -- you have done
22 breast reductions without having results
23 from a randomized controlled clinical

1 trial?

2 A. Oh, forgive me. I -- I
3 misunderstood the question, then. No.
4 The -- I have not, no. The industry --
5 the plastic surgery community does not
6 rely on a randomized trial for the -- the
7 operation to be merited. That's correct.

8 Q. Right. Nobody in this industry
9 waits for results from a randomized
10 controlled trial before determining that
11 a particular surgical procedure is
12 nonexperimental; right?

13 MR. KNEPPER: Objection, form.

14 A. Well, this gets back to what we
15 were talking about before, what the --
16 what the level of evidence is, what's at
17 risk, and what are the potential
18 benefits. So in the case of breast
19 reduction surgery, yes, we have not
20 relied on randomized controlled trials
21 because there was such an abundance of
22 level 3 evidence to justify the
23 procedure. And so -- and level 3

1 evidence is sufficient to answer the
2 question, is this experimental or not?
3 This procedure doesn't rise to the level
4 of level 2 or level 1 in order to be
5 justified. I believe there have been --
6 well, no, I can't say categorically, so I
7 won't.

8 So yeah, to answer your
9 question, breast reduction does not rely
10 on randomized trials. It relies on level
11 3 evidence.

12 Q. All right. Let's take it out of
13 the realm of breast reduction in
14 particular.

15 A. Okay.

16 Q. It is not uncommon for plastic
17 surgeons to perform procedures that are
18 not supported by results from an RCT;
19 correct?

20 MR. KNEPPER: Objection, form.

21 A. As a general principle, plastic
22 surgeons are perhaps more innovative than
23 other surgeons, so we're inclined to try

1 new techniques. And then, of course, you
2 have to exercise some significant
3 prudential judgment about what risk are
4 you placing the patient in before you get
5 experimental with them. Yeah. So yes,
6 we -- we do that all -- we're innovators,
7 as -- as a general principle.

8 Q. And as a general principle,
9 plastic surgeons will often commonly
10 perform procedures that are not supported
11 by level 2 evidence; correct?

12 MR. KNEPPER: Objection, form.

13 A. Yes.

14 Q. And as innovators, plastic
15 surgeons will often perform surgical
16 procedures that are not level 3 evidence;
17 right?

18 MR. KNEPPER: Objection, form.

19 A. Yeah. They -- if you're talking
20 about small like technical improvements
21 in -- in low-risk procedures, then yeah,
22 we -- we do that very commonly.

23 Q. Okay. You know what the

1 Plastics and Reconstructive Surgery
2 journal is; right?

3 A. Yes.

4 Q. It's the official publication of
5 the ASPS; correct?

6 A. Correct.

7 Q. It's a peer-reviewed medical
8 journal; right?

9 A. Correct.

10 Q. It's published monthly; right?

11 A. And plus supplements as well and
12 online. Yes, sir.

13 Q. One purpose of that journal is
14 to educate members about new surgical
15 techniques; right?

16 A. Yes.

17 Q. Would you agree that the journal
18 is the premier peer-reviewed source for
19 current information on reconstructive and
20 cosmetic surgery?

21 A. I would.

22 Q. All right. Are you -- I know
23 that you're no longer a member. Are you

1 still subscribing to the journal?

2 A. No, I'm not. It's a -- it's for
3 members that you get the journal, so
4 yeah. That's what my subscription relied
5 on, so -- all those years.

6 Q. I understand. So not -- you
7 haven't had access to it since 2018?

8 A. Well, I -- no, I go online, and
9 I'll pay for access to particular
10 articles. So yeah. So it's not that
11 I've lost contact with it, it's just that
12 I do literature searches, and if an ASPS
13 citation comes up, I'll pay to look at
14 it.

15 Q. I understand. Sitting here
16 today, what percent of publications in
17 that journal do you think consist of
18 results from RCTs?

19 MR. KNEPPER: Objection, scope,
20 form.

21 A. Yeah, I'm -- I'm not sure I
22 could hazard a guess even.

23 Q. Ballpark, do you think it's 10

1 percent? 50 percent?

2 A. Of their published articles that
3 are randomized controlled trials?

4 Q. Yes.

5 MR. KNEPPER: Objection to form,
6 scope.

7 A. Gosh, I'm going to guess it's
8 probably somewhere -- probably less than
9 10 percent.

10 Q. How about cohort studies? If
11 you had to estimate, what percentage of
12 publications in that journal do you think
13 consist of results from cohort studies?

14 MR. KNEPPER: Objection, form.

15 A. Again, just ballparking here
16 after, you know, 35 years of reading that
17 article -- that journal for 35 years, I
18 would say that -- I don't -- I may be
19 guessing, but 15 percent maybe are -- are
20 cohorts that are usually single-center
21 studies. There's a lot of those in
22 the -- in the White Journal. There'll be
23 a single-center cohort study of -- of

1 some operation or technique, and they'll
2 usually report it as three or four
3 surgeons at a single center reporting a
4 -- a longitudinal cohort of, say, breast
5 cancer reconstructions with implants
6 versus breast reconstruction with
7 autologous flaps and comparing
8 satisfaction surveys and things like
9 that. So I'm going to ballpark it at 15
10 percent, but I don't know. I don't know
11 for a fact.

12 Q. Let me introduce an exhibit. So
13 this will be Exhibit 17, and let me know
14 when you get it.

15 (Exhibit 17 was marked for identification
16 and is attached.)

17 A. Okay. All right. I have it.

18 Q. All right. This is a study from
19 2019 by Sugrue, S-U-G-R-U-E, titled
20 "Levels of Evidence in Plastic and
21 Reconstructive Surgery Research." See
22 that?

23 A. I do.

1 Q. All right. See there's a
2 "Summary" box on the first page?

3 A. Yes.

4 Q. The third sentence says, "The
5 aim of this study is to determine if the
6 quality of evidence in plastic surgery
7 research has improved over the past 10
8 years. Systematic review of research
9 published in Plastics and Reconstructive
10 Surgery journal over the years, 10-year
11 period (2008, 2013, 2018), was
12 performed." Do you see that?

13 A. I do.

14 Q. Now, you understand what this
15 study was trying to accomplish; right?

16 A. Yeah. They were measuring the
17 level of success that the American
18 Society of Plastic Surgery was having
19 after having applied those criteria we
20 talked about earlier, the -- this
21 requirement of reporting levels of
22 evidence, seeking the clarity on levels
23 of evidence. And so I expect -- I

1 haven't read this -- this article before,
2 but I guess that's what they're looking
3 at, is how successful have we been as a
4 professional society in publishing --

5 Q. Yeah.

6 A. -- these things.

7 Q. And this references the levels
8 of evidence, LOE, metric; right?

9 A. Yes.

10 Q. And that's the same metric that
11 you referenced earlier, levels 1 through
12 5; right?

13 A. Right. Well, the levels 1
14 through 5 that I referenced includes
15 the -- sort of the subcategorizing,
16 depending on if it's a therapeutic trial
17 or a -- or a trial of risk or things like
18 that. So the -- the document that the
19 ASPS published some years ago includes
20 risk studies and diagnostic studies, but
21 they're all ranked 1 through 5. That's
22 right.

23 Q. And you see a couple of

1 sentences down, it says 884 studies were
2 included in the final analysis. You see
3 that?

4 A. Yes, I do.

5 Q. Okay. Go to page 2.

6 A. Okay.

7 Q. You see there's a Table 1?

8 A. Yes, I do.

9 Q. Table 1 is "Percentage of Each
10 Level of Evidence Published per Year."
11 Do you see that?

12 A. I do.

13 Q. And there's columns for 2008,
14 2013, and 2018; right?

15 A. Yes.

16 Q. All right. Let's start with
17 level 1, and that's randomized control
18 trials or metaanalyses of those trials;
19 right?

20 A. Right.

21 Q. In 2018, only 2.1 percent of all
22 publications in the journal were level 1
23 evidence; right?

1 A. That's right.

2 Q. And in 2008 and 2013, those
3 percentages were 0.3 and 1.7 percent
4 respectively; correct?

5 A. Correct.

6 Q. Not very common for the journal
7 to report on results of RCTs, according
8 to this summary; right?

9 MR. KNEPPER: Objection, form.

10 A. Yeah. And it even goes along
11 with what -- my ballpark earlier, so I'm
12 surprised -- yes, it was less than 10
13 percent were -- were level 1 evidence and
14 somewhere around -- yeah, so those
15 numbers are consistent. But yeah.

16 And the other thing to note
17 about it is that they appear to have been
18 successful in choosing what they publish
19 to support higher levels of evidence. So
20 I guess they're to be commended for
21 having done this, yeah.

22 Q. Okay. All right. Then level 2
23 are -- level 2 evidence includes

1 prospective cohort or comparative
2 studies; right?

3 A. Yes.

4 Q. With controls; right?

5 A. Yeah. There's a level of
6 randomization that -- that's there as
7 well --

8 Q. Okay.

9 A. -- in those prospective studies.
10 That's right.

11 Q. And for that level 2 evidence,
12 only 13.6 percent of all publications in
13 the journal in 2018 consisted of that
14 evidence; right?

15 A. Yes. That's what it says there,
16 yes.

17 Q. All right. Level of evidence 4
18 is case series with a pre- or posttest or
19 only posttest; right?

20 A. Right.

21 Q. And in 2018, those amounted to
22 41.7 percent of all publications; right?

23 A. Right. It looks as though more

1 of those level 4 have been shifted up
2 into level 3, given that the level 5 has
3 declined. So it looks like they're
4 pushing more of the level 4 up into level
5 5. Yeah.

6 Q. Yeah. Much of the research on
7 which your field relies doesn't consist
8 of results from RCTs or controlled cohort
9 studies; right?

10 A. Well, I wouldn't --

11 MR. KNEPPER: Objection, form.

12 A. I wouldn't say that based on
13 this. I would say that much of the
14 published research in this journal is of
15 that -- of what you described, relying on
16 RCTs and so on.

17 This is a -- this is not a
18 document about what the profession is
19 doing. This is a document about what
20 this journal is publishing. And what
21 they're publishing is more papers of
22 higher value, for which they're to be
23 commended. So this says nothing about

1 what people are investigating. This says
2 about -- this says something about what
3 this journal is publishing.

4 Q. Well, this is the journal for
5 the ASPS; right?

6 A. Right. With limited space for
7 publication. So they're being,
8 apparently, more selective about what
9 they'll publish, that it's not just that
10 well, this is the chief of plastic
11 surgery at NYU, so we're going to publish
12 his paper. It's the chief of plastic
13 surgery has a level 2 case. Let's --
14 let's present -- let's publish that one.
15 I think that's what this is telling us,
16 that they're being more fastidious about
17 what they publish, whereas before, they
18 might have been more -- well, less
19 selective, let's say.

20 Q. Have you ever been involved with
21 selecting articles to be published in
22 this journal?

23 A. I've never been involved in --

1 in journal publication staff or -- no, I
2 have not.

3 Q. You don't know the process by
4 which they select what article to
5 publish; right?

6 MR. KNEPPER: Objection, form.

7 A. I have some idea, but I'm --
8 it's not my -- my area of professional
9 expertise.

10 Q. Yeah.

11 A. I merely read the journal, and
12 have for approaching forty years now.

13 Q. Look at Table 2.

14 A. Okay.

15 Q. And look at the column under
16 2018.

17 A. Yes.

18 Q. The first two rows, "Systematic
19 review/meta analysis" and "Randomized
20 control trials," account for 3.2 plus 3.8
21 percent of all publications of the
22 journal in 2018. Correct?

23 A. Right.

1 MR. KNEPPER: Objection.

2 Q. Case series account for 26.3
3 percent; right?

4 A. Right.

5 Q. Okay. Go to page 3 of this
6 exhibit.

7 A. Okay. I'm there.

8 Q. All right. First full
9 paragraph, first sentence says, "Case
10 series are the backbone of surgical
11 research." Do you see that?

12 A. I do.

13 Q. You don't disagree that case
14 series can be helpful scientific
15 evidence; right?

16 A. No. As I -- as I testified
17 before, this is the beginning of
18 research. It always begins with perhaps
19 a serendipitous discovery, then to case
20 reports, then to case series, single --
21 single-provider case series or multiple
22 providers in a -- in a -- an institution.
23 But that's the beginning of surgical

1 research, yeah. That's how it always
2 begins.

3 Q. Well, it's a beginning, but
4 sometimes it's also the end; right?
5 Because look at the third sentence. It
6 says: "The absence of a control group
7 justifiably ranks this design at the
8 lower end of the evidence pyramid.

9 Despite this, case series are vital.
10 They may be the only feasible and ethical
11 study methodology obtainable, as seen
12 with craniofacial surgery." You see
13 that?

14 A. Yeah. And to that -- to that
15 particular point, so I've got extensive
16 experience with craniofacial surgery, and
17 -- and it's -- this is one of those
18 procedures where the outward change to
19 the child can't be blinded. You cannot
20 blind the investigator because,
21 obviously, he's doing the surgery, and
22 you can't blind the patient or the family
23 to it because the results are quite

1 obvious. And that's what they're saying
2 here. And obviously, they're not saying
3 that it's never useful or is never
4 necessary. They're saying that in many
5 cases, you don't need to rise to that
6 level because you have evident benefit to
7 the patient and the risk is not only
8 manageable but -- but sufficiently low to
9 warrant the application of a particular
10 technique.

11 So that was certainly the case,
12 for example, when we introduced external
13 fixation devices for advancement of the
14 mid face in certain congenital
15 deformities. Nobody had done a
16 randomized trial because you can't.
17 You've got this hardware sitting on the
18 patient's face. So -- but yet, the --
19 the luminaries in craniofacial surgery
20 were able to demonstrate through a case
21 series that this was a valid technique,
22 and then the rest of us adopted it. So
23 that's an example of how plastic surgery

1 works.

2 Now, if the patient was at risk
3 of death because this technique was being
4 applied or if the patient was at risk of
5 permanent life-altering changes that
6 couldn't be reversed, then yeah, you
7 would have to proceed with much greater
8 caution, and you may be looking at
9 finding some way, longitudinal
10 study-wise, to -- to quantify the benefit
11 of using your technique over using
12 established techniques.

13 Q. There are some areas in plastic
14 surgery and reconstructive surgery where
15 case series are basically as good as it
16 gets in terms of scientific evidence;
17 right?

18 MR. KNEPPER: Objection, form.

19 A. Yeah. I suppose in the newer --
20 at the newer end of techniques, that's
21 all you got for now until the technique
22 has been applied over a sufficiently long
23 time that you can look at a retrospective

1 cohort.

2 So for example, in the case of
3 gender transitioning surgery, the -- the
4 -- the surgeons have been at it now for
5 several decades. And we should be
6 already at the level of level 3 evidence,
7 but -- but we're not.

8 Q. Well, you --

9 A. So I wouldn't put that in the
10 category of -- you're talking there about
11 a high-risk procedure that has a long
12 track record that can be examined. And
13 -- and clearly, the examination of that
14 technique in the last three years, give
15 or take, has -- has shown us that that
16 this is in the category of those
17 operations that demand higher levels of
18 evidence than a case series, whether it's
19 single provider, single institution, or
20 even single nation. You've got to --
21 you've got to look at the data now and --
22 and prove that you are doing something
23 good for the patient.

1 And quite frankly, it hasn't
2 been proven in the -- in the American
3 literature. Certainly, WPATH hasn't
4 proven that. But in the European
5 literature, they're looking at it and
6 saying, gosh, you know, the -- the
7 Swedish study shows us that if you only
8 follow patients for five years at the
9 most, you're not even going to see the
10 long-term effect of what you did to them.
11 And if you look at them eight years and
12 beyond, you'll see that you haven't
13 solved the suicidality, the self-harm,
14 the incarceration, psychiatric diagnosis
15 admissions, and things like that.

16 So -- so yeah, as far as what
17 we're talking about today, yeah, there's
18 a whole spectrum of what's acceptable
19 levels of evidence for a particular
20 procedure. The higher the risk, the
21 higher the level of evidence is demanded.
22 And sometimes you have to wait to get to
23 that level of evidence if you're dealing

1 with something potentially
2 life-threatening.

3 Like certainly, the providers
4 were fully justified in considering this
5 because of the high suicide rate of
6 transgender patients. Case series,
7 totally valid reason given that the life
8 of the patient is at risk here, totally
9 valid to go with a case series as the
10 evidence by which you're consenting the
11 patient to surgery. But we're now beyond
12 that. We're now beyond that. We're at
13 -- we're now -- the ethics demands that
14 we look at higher levels of evidence
15 because of the long-term risk to the
16 patient and the fact that the long-term
17 evidence doesn't support the indication
18 for surgery, which is lower suicide rate,
19 lower self-harm, lower drug abuse.
20 That's really what we're talking about
21 here.

22 Q. I have some other questions.
23 You agree that -- strike that.

1 Do you agree that it is not
2 possible to perform RCTs for some
3 surgical procedure because you can't
4 blind the patient or the investigator to
5 what the procedure is?

6 A. Absolutely agree, yeah.

7 Q. So, let's take phalloplasty;
8 right?

9 A. Okay. Yeah.

10 Q. When a surgeon performs a
11 phalloplasty on a patient, both the
12 surgeon and the patient are going to know
13 that the procedure was done; right?

14 A. Yes.

15 Q. It's not possible to have a RCT
16 for phalloplasty because you can't blind
17 the participant or the investigator;
18 right?

19 A. Yeah. That's typical of most
20 surgical interventions. The only
21 exception to that would be intraabdominal
22 or intrathoracic surgeries or even
23 intracranial surgeries. And -- and

1 that's considered sham surgery, which is
2 considered malpractice and ethical
3 violation of professional standards. So
4 you can pretty much rule out most all
5 surgical procedures from the randomized
6 control trial category. Correct.

7 Q. And we agree that the same would
8 apply to metoidioplasty, for example;
9 right?

10 A. Yes.

11 Q. To all types of, again,
12 colloquially known as bottom surgery;
13 right?

14 A. Correct.

15 Q. All right. Let's take
16 puberty-blocking hormones.

17 A. Okay.

18 Q. When patients with gender
19 dysphoria treatment start
20 puberty-blocking hormones, they're not
21 going to undergo puberty, basically;
22 right?

23 A. Well, that's the intended use,

1 that's correct.

2 Q. So there's going to be
3 observable physical effects of the
4 hormones that will be apparent to the
5 patient; right?

6 A. Yes. Within a year, that child
7 is going to look much smaller than his
8 peers. He's going to be developmentally
9 delayed psychologically,
10 neurophysiologically. His -- his
11 movements are not going to be as -- his
12 coordination is going to be less matured.
13 His higher executive functions will be
14 impaired. So it will be very obvious
15 that this child is now different from his
16 peers. So I would agree with you; you
17 couldn't find a way to blind such a study
18 because the evidence of effect is so
19 obvious within the first year that
20 everyone would know that they're taking
21 the -- the puberty-blocking
22 gonadotropin-releasing hormone agonist.

23 Q. We agree that -- we agree that

1 it's not possible to do an RCT for
2 puberty-blocking hormones because of
3 these apparent physical effects; right?

4 MR. KNEPPER: Objection, form.

5 A. -- I would agree, yes.

6 Q. Okay. Let's take cross-sex
7 hormones.

8 A. And the -- the last question you
9 asked me, did you qualify that as you
10 couldn't do a double-blinded study using
11 puberty-blocking drugs in self-identified
12 transgender children?

13 Q. Yes.

14 A. Yeah. Because if you're
15 applying the drug to other conditions
16 like precocious puberty, it -- it may be
17 possible. It may be possible to -- I
18 don't know. I'd have to think about that
19 but -- okay. Sorry.

20 Q. Let's take cross-sex hormones.

21 A. Okay.

22 Q. When somebody -- someone is
23 treated with estrogen or testosterone for

1 gender dysphoria, there are also going to
2 be physical effects from those
3 treatments; correct?

4 A. Yes. Given that sex hormones
5 have such a profound effect on every body
6 system, then it's going to be impossible
7 to conceal the fact that the person is on
8 sex hormones because every -- every
9 function of the body is affected by sex
10 hormone levels, particularly at the age
11 of early adolescence.

12 Q. And given these visible physical
13 effects, it's not possible to design a
14 double-blind RCT for cross-sex hormones
15 for gender dysphoria; correct?

16 A. It would probably be an invalid
17 study, yes.

18 Q. All right. Let's go back to
19 your -- actually, you know what? I'm
20 going to move to a different area. It's
21 been about an hour. Let's take a quick
22 break.

23 MR. TISHYEVICH: Off the record.

1 THE VIDEOGRAPHER: This is the
2 end of Media Unit No. 4. We are off the
3 record at 2:16 p.m.

4 (Break taken.)

5 THE VIDEOGRAPHER: This is the
6 beginning of Media Unit No. 5. We are on
7 the record at 2:24 p.m.

8 Q. (By Mr. Tishyevich) Let's go
9 back to your report, Exhibit 1.

10 A. Okay.

11 Q. Go to page 21.

12 A. Twenty-one. Okay.

13 Q. And you see there's a paragraph
14 starting with, "Failure to discuss the
15 failure to conduct"?

16 A. Yes.

17 Q. Okay. So in the second line,
18 you reference the "unknown number and
19 percentage of patients who drop out of
20 transitioning or reverse the process
21 parentheses (Detransitioners)."

22 A. Right.

23 Q. You see that?

1 A. I do.

2 Q. All right. You agree that the
3 number and percentage of patients with
4 gender dysphoria who drop out of
5 transitioning or who reverse the process
6 is currently unknown; right?

7 A. Well, it depends on if you're
8 asking that question about the general
9 population or in a particular study. So
10 in particular studies, that number is
11 known, but in the general population,
12 it's an unknown.

13 Q. Yeah.

14 A. And the reason -- the reason
15 it's unknown in the general population is
16 because the people doing the research
17 aren't following those patients. That's
18 why we don't know.

19 Q. In the overall population, the
20 number and percentage of patients who
21 drop out of transitioning or reverse the
22 process is unknown; agree?

23 A. Yeah. I would agree that's

1 unknown, yeah.

2 Q. All right. Given that,
3 obviously, you're not offering any expert
4 opinions on what that number or
5 percentage is in the general population;
6 right?

7 A. Yeah, I don't -- I don't think
8 it's possible for anyone to break out the
9 difference, for example, between somebody
10 who isn't followed up because they've
11 detransitioned or somebody who isn't
12 followed up because they've taken their
13 own life. We have no way of knowing
14 because nobody's following up.

15 Q. All right. Look toward the
16 bottom of this page 21. You cite a case
17 series from I believe it's Djordjevic,
18 D-J-O-R-D-J-E-V-I-C. Do you see that?

19 A. I do.

20 Q. And you say, "More dramatically,
21 a surgical group prominently active in
22 the SRS field has published a report on a
23 series of seven male-to-female patients

1 requesting surgery to transform their
2 surgically constructed female genitalia
3 back to their original male form."
4 Right?

5 A. I see that, yes.

6 Q. Okay. Now, this article was not
7 an RCT, obviously; right?

8 A. Right, right.

9 Q. It was not a cohort study;
10 right?

11 A. No. This would be a case -- a
12 case series.

13 Q. Yeah. The lowest level of
14 evidence; right?

15 A. No. Actually, the lowest level
16 of evidence would be sort of single
17 patient -- well, it's sort of somewhere
18 between 4 and 5, I suppose. I'd have to
19 look at the article again to see what the
20 -- what the denominator is, but --

21 Q. Yeah. Well, generally, you
22 think that anecdotal patient stories like
23 these are not reliable scientific

1 information; right?

2 MR. KNEPPER: Objection, form.

3 A. No. They're the first clue to a
4 problem or the first clue to a solution.
5 That's exactly right. So that -- that
6 sort of points to the controversial
7 nature of these therapies, is that -- is
8 that we don't have the answer. We can't
9 explain why these detransitioners weren't
10 predicted preoperatively because we don't
11 have a test instrument to figure that
12 out.

13 So when you see a series like
14 this -- this is what we talked about
15 earlier, about the -- the history of
16 progression of levels of evidence. You
17 start out with reports like this. This
18 leads to further research. And I'm just
19 trying to remember, when I read the
20 article, where that study was done. I
21 don't have it in front -- I'm just trying
22 to remember what -- what country that was
23 done in.

1 Q. Yeah. I'll -- I'll show it to
2 you.

3 A. Okay.

4 Q. Hold on. Let me introduce it.

5 A. Thank you.

6 Q. You did read these -- this
7 article in full before you cited it;
8 right?

9 A. Yeah. That -- it was -- it was
10 probably about seven months ago, but yes,
11 I did.

12 Q. Sure.

13 THE COURT REPORTER: I didn't
14 hear anything. So it's just --

15 THE WITNESS: Okay.

16 THE COURT REPORTER: We're
17 losing it in Zoom. Thank you.

18 THE WITNESS: Forgive me. I'm
19 sorry.

20 THE COURT REPORTER: No, that's
21 okay. It's awkward.

22 Q. (By Mr. Tishyevich) Okay. This
23 is going to be Exhibit 18, and let me

1 know when you have it.

2 (Exhibit 18 was marked for identification
3 and is attached.)

4 A. Okay. Okay. Yeah, there it is.

5 Yes. Yeah, right. Okay. It's coming
6 back to me now. And this was published
7 out of the -- Amsterdam. That's right.
8 Okay. All right. Yeah.

9 Q. All right. Let me ask you --
10 strike that.

11 Bottom of the page, there's a
12 section titled "Introduction." You see
13 that?

14 A. The bottom of the first page?

15 Q. Yes.

16 A. Yes, I see that.

17 Q. Look at -- look to the column on
18 the right.

19 A. Okay.

20 Q. The last sentence says, "In
21 general, most researchers have reported
22 their patients are extremely satisfied
23 overall with their surgical outcomes,

1 with a low rate of complications." You
2 see that?

3 (Witness reviews document.)

4 A. Right. I see -- I do see that,
5 yes.

6 Q. Then it cites three footnotes, 5
7 through 7; right?

8 A. Right.

9 Q. You don't acknowledge this
10 portion of the article in your report;
11 right?

12 A. Well, it is in the discussion, I
13 think. Well, actually, probably maybe in
14 the summary of the -- of the medical
15 evidence. The -- I would put this in the
16 category of subjective reporting and short
17 follow-up. Right. That's what --

18 Q. Well, you --

19 A. I'm sorry. Go ahead.

20 Q. No, no, go ahead.

21 A. So I think the reason I included
22 this was to show that there are -- you

1 know, that there's a growing pool of
2 patients who are returning for reversal
3 surgery. I don't think I discussed in
4 this part of my report -- yeah. I'm just
5 talking about increasingly visible
6 community and patient -- increasing
7 number of patients requesting reversal
8 surgery. And as an example of that,
9 again, going to a single-center case
10 collection as an example, early evidence,
11 we're starting to see this now as numbers
12 of patients who have surgically
13 transitioned increases, the numbers of
14 patients who regret is going to increase,
15 particularly in light of what these
16 authors speak about here.

17 Let me see if I -- yeah. So in
18 the second sentence of the abstract in
19 the introduction, it says, "However,
20 misdiagnosed patients sometimes regret
21 their decisions." And one of the reasons
22 for including this article is the fact
23 that misdiagnosis is not measured. The

1 world literature doesn't present error
2 rates. This would be what I would
3 consider an error rate, that an erroneous
4 diagnosis was acted upon surgically,
5 leading to this complication of regret
6 and a -- and a desire for reversal.
7
8 Yeah.

9
10 Q. Your expert testimony is that
11 there's no data available on the
12 percentage of people who have received
13 treatment for gender dysphoria who
14 experience regret?

15 A. Yeah. It's very, very low --
16 low-level evidence right now. It's
17 basically we're in the -- we're in the
18 case collection study, whereas actually
19 in the -- well, that's not regret. But
20 -- but perhaps in the category of
21 misdiagnosis would be the -- the reports
22 out of Sweden, certainly the -- yeah, so
23 beginning with the Swede -- Swedish
 studies by Cecilia Dhejne and others that
 shows us a lack of efficacy. Whether or

1 not the patient presented for reversal is
2 definitely an unknown number, definitely.

3 Q. All right. That study doesn't
4 quantify anything about patient regret;
5 right?

6 A. The Swedish study does not. It
7 quantifies lack of -- of effect from the
8 surgical interventions. Lack of benefit,
9 I should say.

10 Q. Go to page -- PDF page 7 of this
11 document and look at the Conclusions --

12 A. Okay.

13 Q. -- section.

14 A. All right. Let's see that page.
15 Conclusions. Okay. I'm there.

16 Q. The first sentence says, "The
17 vast majority of properly diagnosed
18 transsexual patients are satisfied with
19 their decision to undergo SRS, with only
20 a few coming to regret it." Right?

21 A. Right. So this -- the other
22 reason why this study is useful to our
23 conversation is that this is the same

1 language and the same metrics that's used
2 to describe the success of cosmetic
3 surgery. They don't include in here,
4 apart from the regret number that they're
5 actually publishing here -- not number
6 but the examples, I should say. They
7 don't include in their -- in their
8 conclusions any statement about objective
9 quantifiable benefit from the surgery.
10 They talk about subjective reporting.

11 So this is an example of a -- of
12 a peer-reviewed journal article that
13 measures the efficacy of this surgery
14 based solely upon a satisfaction survey
15 of patients who have returned for
16 follow-up, so this would be an example of
17 that. Yes, sir.

18 Q. Do you know what metric was used
19 to measure satisfaction or
20 nonsatisfaction in these studies?

21 A. I'd have to reread the -- the
22 methods and materials here, but I
23 would -- I would guess it was one of the

1 approved instruments for measuring
2 satisfaction. There are a variety of
3 test instruments used for -- in
4 satisfaction surveys, particularly in the
5 world of plastic surgery.

6 Let's see. They used the --
7 these are the kind of things I don't keep
8 in my long-term memory here for a
9 particular article. Okay.

10 (Witness reviews document.)

11 A. Okay. There's the outcomes
12 measures. Forgive me for eating up your
13 time.

14 Q. Let me -- let help you, Doctor.
15 Go to page --

16 A. Okay. There it is.

17 Q. -- PDF page 5.

18 A. Yeah. Fif- -- yeah.

19 Q. Yeah.

20 A. Fifteen, right.

21 Q. Question on the page --

22 A. So there's a -- there's a test
23 instrument there. Right.

1 Q. Yeah. There's a test instrument
2 that measures things like erectile
3 function, sexual desire, orgasmic
4 function, intercourse satisfaction, and
5 overall satisfaction; right?

6 A. Right.

7 Q. They don't just ask the patient,
8 "Hey, are you happy with the surgery?"
9 There's five criteria that are applied;
10 right?

11 A. Right.

12 Q. This is an approved instrument
13 for measuring this type of satisfaction
14 for surgery; right?

15 MR. KNEPPER: Objection, form.

16 A. This is -- this is -- yeah, it's
17 definitely a valuable instrument for
18 measuring things, but none of them are
19 the -- are the indication for surgery,
20 which is things like reduced suicidality,
21 reduced self-harm, reduced alcohol use,
22 all of those other things which are --
23 which are the reason, the indication for

1 the operation. So you generally try to
2 match the surgical procedure with the
3 indication for the surgery.

4 They're measuring things that
5 weren't involved in the indications for
6 surgery. They didn't get, you know,
7 reconstructive surgical approval so that
8 they could achieve erections, for
9 example. This was approved because of
10 the risk of self-harm, suicide, those
11 sorts of things. Yeah. But none of
12 those are measured. They -- it is -- it
13 is they do have objective measures, and
14 this is one of the -- one of the values
15 of this study. But I don't think they
16 report the complication rate in this
17 study, as I recall.

18 Q. This -- this study specifically
19 did not purport to seek out anything
20 about suicidality or mortality or other
21 adverse outcomes of that nature; right?

22 A. Let's see. I'm trying to
23 remember in their introduction.

(Witness reviews document.)

A. Yeah. I think their indications used language that was more consistent with -- with aesthetic, aesthetic surgery rather than the reconstructive language. So yeah

(Witness reviews document.)

A. Yeah. So --

Q. Yeah. Here's --

A. Yeah, I would --

Q. Here's what I find interesting,
Doctor

A. Okay.

Q. Your report cites this one case series of seven patients to make the point that there's this regret occurring without even mentioning that there's multiple case series that say the vast majority of these patients end up being satisfied with this type of surgery?

A. No. I don't think --

Q. You don't think that's appropriate to mention?

1 A. No. I -- actually, what I
2 present these examples to show, that --
3 that the literature in support of these
4 surgeries is characterized by very short
5 follow-up and subjective reporting. So
6 this is an example of some objective
7 reporting, mostly subjective reporting.
8 And most of the articles, for example,
9 that you just asked me about involve
10 subjective reporting and short follow-up.
11 That's right, yeah.

12 Q. All right.

13 A. And in this case, you also --
14 I'm -- I'm pleased that they reported
15 that one, two, three, four, five, six,
16 seven -- so nearly half of their patients
17 had a surgical complication of a urethral
18 fistula, and if you have a urethral
19 fistula and you have a malleable
20 prosthesis, probably they went on to
21 remove the prosthesis as well. But
22 that's -- I mean, I -- props for this --
23 this team that they reported their

1 complications.

2 Q. Where -- what page is the
3 complications portion you're looking at?

4 A. That's on -- just before you get
5 -- the last page before the -- the same
6 page as the conclusions. There's a table
7 at the top, and they have the seven
8 patients, and you can see -- what's also
9 interesting here, too, is -- is that if
10 you look at the period after sex
11 reassignment surgery, that the -- that
12 the dissatisfaction level really kicks in
13 when you're beyond eight years.

14 Actually, if you look at even six years
15 beyond.

16 Initially, there's no patients
17 reporting dissatisfaction at anything
18 less than five years, and so this is
19 actually further evidence of the -- of
20 the inadequacy of the -- the papers that
21 are in the literature right now which
22 have follow-ups that are typically two to
23 three years. So none of these patients

1 would have been seen, with most of the
2 literature that supports these
3 techniques, as a way to, you know, avoid
4 -- avoid dissatisfaction or -- or
5 suicidality or drug use or anything else
6 like that. So that's an interesting -- I
7 hadn't noticed that before, but yeah.

8 Q. Yeah. Are you reading Table 1
9 to say that these complications like
10 urethral fistula and stricture were from
11 the original surgery?

12 A. Well, I'm -- I'm merely --

13 Q. Or is it from the reversal
14 surgery that was being done later?

15 A. So they're talking here about
16 flaps. They're talking about
17 complications from the -- the -- the
18 surgeries. Yeah. So this --

19 Q. Yeah. This is --

20 A. They're speaking about urethral
21 fistulas and strictures are the main
22 problem after total phalloplasty. So
23 that's the construct of the counterfeit

1 phallus because of insufficient vascular
2 supply. I also discuss that in my
3 complications section. These are
4 characteristic complications of these
5 free flaps, radial forearm free flaps,
6 and you see those complications here.
7 And you even see them later in -- in the
8 case, so. Some of them are step
9 procedures. In fact, all of them are.

10 Q. All right. Let me -- let me
11 show you another study.

12 A. Okay.

13 Q. Let me reintroduce this with an
14 exhibit -- exhibit stamp. Give me a
15 second. All right. I'm reintroducing
16 this as Exhibit 20. Let me know when you
17 have it.

18 (Exhibit 20 was marked for identification
19 and is attached.)

20 A. I just got Exhibit 19. Is there
21 another? There's a 20 to follow?

22 Q. It -- it should load
23 momentarily. Yeah.

1 A. Oh, I'm sorry.

2 MR. KNEPPER: Are 19 and 20 the
3 same, just one's missing the little
4 stamp?

5 MR. TISHYEVICH: Correct.

6 THE WITNESS: Okay. I'll just
7 go to 20, then, when it comes in.

8 Q. Okay. This is a study titled
9 "The Amsterdam Cohort of Gender Dysphoria
10 Study (1972-2015): Trends in Prevalence,
11 Treatment, and Regrets." Do you see
12 that?

13 A. I do.

14 Q. And then it's by an author,
15 let's say Wiepjes, W-I-E-P-J-E-S.

16 A. Yeah.

17 Q. Right?

18 A. I agree.

19 Q. Have you seen this study before?

20 A. I'm trying to gloss it to see if
21 I've read this before. I -- I may have.
22 Give me just a moment, if that's okay.

23 Q. Sure.

(Witness reviews document.)

A. Yeah, this looks familiar.

Q. I don't think I saw this in your report, but tell me if you remember otherwise.

(Witness reviews document.)

A. Yeah, no. I remember this being evidence of the growing population of self-reported transgender patients, and it's a retro- --

O. Okay. Let me --

A. -- retrospective trial. Yeah.

O. Yeah. Let's go through this.

A. Retrospective study, I should say

Q. All right. You see the "Abstract" section on the first page?

A. I do.

Q. See the "Results" section?

A . I do .

Q. It says, "6,793 people (4,432 birth-assigned male, 2,361 birth-assigned female) visited our gender identity

1 clinic from 1972 through 2015." See
2 that?

3 A. I do.

4 Q. All right. So you understand
5 that as part of this study, the authors
6 reviewed medical records of 6,793 people
7 who visited this gender identity clinic
8 from 1972 to 2015; right?

9 A. I do.

10 Q. All right. And you see the
11 "Strengths and Limitations" section?

12 A. Yes, I do.

13 Q. And you understand that this
14 Dutch gender identity clinic treats more
15 than 95 percent of the transgender
16 population in the Netherlands; right?

17 A. Right.

18 Q. Pretty comprehensive study;
19 right?

20 MR. KNEPPER: Objection, form.

21 A. As of 2015, yes. So it's a
22 7-year-old study, and it's -- it's
23 certainly large in numbers, that's for

1 sure. So it's a retrospective chart
2 review of patients visiting the -- the
3 center in the Netherlands, and it's -- it
4 concludes in 2015.

5 Q. This is certainly a better study
6 than that seven series case report that
7 you cited in your report; right?

8 A. It's a different type of study.
9 Yes, it is. Right.

10 Q. Yeah. This study reports on
11 6,793 people, whereas the case series on
12 which you rely has seven what you call
13 anecdotes; right?

14 A. I wouldn't say I relied on that
15 study. I merely presented it as an
16 example of -- of reporting on transgender
17 regret. I didn't present it as a study
18 that I relied all my opinions on.
19 Certainly, there's other study types and
20 other studies in the literature that --
21 that one might rely more heavily on.

22 Q. Well, let the --

23 A. A retro- -- a retrospective

1 chart review, for example, might be more
2 useful.

3 Q. Yeah.

4 A. But not -- not definitive. And
5 again, we've got to examine the fact that
6 we're looking at old data here.

7 Q. Well, let's see what this
8 30-year retrospective review found. Look
9 at the "Results" section.

10 A. Scroll down. Okay.

11 Q. Look at the last two sentences.
12 "The percentage of people who underwent
13 gonadectomy within 5 years after starting
14 HT remained stable over time" --

15 A. Right.

16 Q. -- "(74.7% of transwomen and
17 83.8% of transmen). Only 0.6% of
18 transwomen and 0.3% percent of transmen
19 who underwent gonadectomy were identified
20 as experiencing regret." Do you see
21 that?

22 A. I do. And that has caused me to
23 want to look back and see -- okay. So

1 they started with the 6,800, roughly, and
2 they report on 6,000 -- 7,000 almost.

3 Okay. And clinic. Okay. And increase.

4 So I'm just trying to see if
5 they reported the average follow-up.
6 They're reporting when they underwent
7 gonadectomy after starting hormone
8 therapy, but they don't report the length
9 of follow-up, which is one of the key
10 reporting points there, because regret,
11 as we talked about earlier, is a -- tends
12 to be a function of time postsurgically.
13 So, let's just scroll down because it's
14 been a long time since I looked at this
15 article. Transwomen, transmen total
16 underwent gonadectomy.

17 Yeah. As I recall, they don't
18 report average follow-up time. Every
19 five-year cohort. So they're looking --
20 they -- they did look at when they
21 entered the system. Prevalence and
22 treatment. Confidence interval.

23 Yeah, as I -- yes. So I think

1 that's -- this is coming back to me now.
2 I think they didn't report the average
3 follow-up or the -- let's see if I'm
4 missing something here. Age for each
5 year, so they did break them out in age
6 that they -- they entered the -- the
7 process, the years during which they
8 entered the process, age groups. And
9 yeah, I think that's -- that was one of
10 the -- one of the issues.

11 And this is -- consonant with --
12 with a lot of the literature, is they
13 don't report the follow-up interval. And
14 that's what the Swedish study is showing
15 us, that if -- if you don't have a handle
16 on the length of follow-up after sex
17 reassignment surgery, then you don't have
18 a -- you don't have any way to fully
19 understand the issue of lack of efficacy
20 or regret.

21 If you're asking the questions
22 is the surgery effective in correcting
23 the most calamitous problems that a

1 transgender person has, which is
2 suicidality, self-harm, and all those
3 things that we talked about earlier, then
4 you have to look at the interval
5 postsurgery in order to have a full
6 understanding of the efficacy of the
7 procedure. And as I recall now, looking
8 it over again, this study does not report
9 on the follow-up period. The median age
10 at first visit was younger, 25. Yeah.
11 So they talk about age. They talk about
12 the years in which they were cared for,
13 but they don't talk about the length of
14 the follow-up interval, so.

15 Q. All right. Let me move on --

16 A. Okay.

17 Q. -- to save time.

18 A. All right.

19 Q. Go to page 4 and where it says
20 "Regret."

21 A. Okay.

22 Q. You with me?

23 A. I am.

1 Q. Third sentence says -- fourth
2 sentence says, "Reasons for regret were
3 divided into social regret, true regret,
4 or feeling non-binary." You see that?

5 A. I do.

6 Q. And social regret -- strike
7 that.

8 It says, "Transwomen who were
9 classified as having social regret still
10 identified as women, but reported reasons
11 such as 'ignored by surroundings' or 'the
12 loss of relatives is a large sacrifice'
13 for returning to the male role." Do you
14 see that?

15 A. I do.

16 Q. All right. So some of the
17 persons who are being counted as
18 experiencing regret in the study did not
19 experience regret in the sense of they're
20 realizing they're not transgender; right?

21 A. Realizing they're not
22 transgender? I'm -- I'm trying to
23 understand your question here. So you're

1 -- you're pointing me to the -- social
2 regret, true regret, feeling non-binary
3 is what's stated here.

4 "Transwomen who were classified
5 as having social regret still identified
6 as women, but reported reasons such as
7 'ignored by surroundings' or 'the loss of
8 relatives is a large sacrifice' for
9 returning to the male role."

10 Okay. Yeah. So -- so it's --
11 it's reporting without quantifying the
12 reasons for regret and the -- basically
13 all of them, subjective reporting again,
14 so -- okay.

15 Q. Well -- well, let's go to page
16 6.

17 A. That's the next page, isn't it?
18 Am I on the right page?

19 Q. On page 6, it has a large
20 vertical table on the left side.

21 A. Okay. There we are.

22 Q. And you may want to rotate it so
23 that you can see that table 6.

1 A. When I got -- let's see.

2 There's a way to do that, isn't there?

3 THE COURT REPORTER: Yeah. If
4 you put your cursor over the document, a
5 black rectangle will come up at the
6 bottom.

7 THE WITNESS: I see it now.

8 Yes.

9 THE COURT REPORTER: There you
10 go.

11 THE WITNESS: All right. There
12 we are.

13 Q. Table 4 is titled
14 "Characteristics of people with regret."

15 A. Okay.

16 Q. According to this table, out of
17 6,793 patients who received treatment, 14
18 of them reported regret of any type;
19 right?

20 A. Okay.

21 Q. And all the way on the right,
22 you see there's a "Reason for regret"
23 column; right?

1 A. Right.

2 Q. And you're welcome to count it,
3 but by my count, only 7 of those 14
4 reported, quote, unquote, true regret;
5 right?

6 A. Yeah. And what's interesting
7 about that is that those are the same
8 criteria that were used to seek
9 transgender surgery to solve their
10 interior problems. So many patients will
11 present for care because they feel
12 socially isolated and because they have,
13 you know, issues of -- well, for example,
14 being non-binary and so on, those --
15 those -- like social acceptance and
16 feeling non-binary is among the
17 indications for the procedure. So it's
18 interesting to note also that time after
19 surgery, the regrettters seem to favor --
20 postsurgical, you start to see them,
21 what, maybe 50 to 90 months out and a lot
22 of them, years -- ten years out. Yeah.
23 So that -- that speaks to what we talked

1 about earlier, that you see these regrets
2 and these problems beyond five years.

3 Q. All right. Whatever criticism
4 you have of the methodology, what the
5 study reports is -- are rates of regret
6 that are below 1 percent; right?

7 MR. KNEPPER: Objection, form.

8 A. Yeah. Again, so as we talked
9 about earlier, that's the problem with
10 this study, is that -- is that the -- the
11 denominator is a much larger number than
12 these 14 patients, and they don't address
13 the length of follow-up out of which they
14 extracted these 14 patients. So it makes
15 it difficult to interpret the study, and
16 the claim that it's a small number is
17 hard to support by their own evidence
18 because they didn't follow them long
19 enough. As their own data shows, you got
20 to follow them longer to see the regret
21 in most patients. And they don't tell us
22 what that number is.

23 Q. Are you aware that there are

1 studies on patient regret outside of the
2 treatment for gender dysphoria?

3 A. Am I aware of -- of transgender
4 transition regret outside of --

5 Q. No. I'm going to ask -- I'm
6 going to ask this again.

7 A. I'm sorry.

8 Q. Are you aware there are studies
9 on rates of patient regret outside of
10 surgical treatment for gender dysphoria?

11 A. Yes. Absolutely, yeah. So --

12 Q. Okay.

13 A. One of the -- one of the most
14 important --

15 Q. Okay. Let me ask -- yeah,
16 Doctor, let's -- this is going to be a
17 long day. Just listen to my questions.

18 Did you do a literature search
19 to find out what the average rates of
20 patient regret are for other surgical
21 procedures compared to surgical treatment
22 for gender dysphoria?

23 A. I did not.

1 Q. Do you know if those rates are
2 higher, lower, or about the same as the
3 rates of regret for surgical treatment
4 for gender dysphoria?

5 A. I would say there's no way of
6 knowing because we don't have the -- the
7 rate of regret in transgender regrettters.
8 We don't have that number, so there's no
9 way to compare or to know which is the
10 higher number.

11 Q. Okay.

12 A. Like we talked about earlier, we
13 don't have this number.

14 Q. Well, this one study I just
15 showed you showed a finding of 0.3
16 percent to 0.6 percent; right?

17 A. Right. And I -- and as I said,
18 this is -- this is -- it's difficult to
19 use this to compare to other regret cases
20 because of the poor quality of this
21 study. So I can't use this to compare it
22 to the other studies on regret because
23 this is not -- not useful to that end. I

1 mean, it's useful in seeing that 14 -- 14
2 regretters had these complications, 14
3 regretters had these -- these
4 explanations for their regret.

5 And so it's kind of like a case
6 collection, and retrospective reviews of
7 -- of patient records are helpful in
8 getting a sense of the size of the
9 problem. Certainly, this study shows us
10 that there's an increasing patient pool
11 of people who self-identify as
12 transgender. So in that regard, this
13 publication is very useful. But in terms
14 of comparing the regret rate based on
15 this paper, I'd say this paper is
16 useless.

17 Q. Okay. Open Exhibit 21.
18 (Exhibit 21 was marked for identification
19 and is attached.)

20 A. Okay.

21 Q. Let me know when you have it.

22 A. Okay.

23 Q. All right. This is a

1 publication from 2017 by Wilson,
2 W-I-L-S-O-N, titled "Regret in Surgical
3 Decision Making: a Systematic Review of
4 Patient and Physician Perspectives." See
5 that?

6 A. I do.

7 Q. All right. Look at the
8 abstract. You with me?

9 A. I'm -- I'm looking -- I'm just
10 reading it now.

11 Q. The third sentence says, "We
12 performed a systematic review of the
13 literature focused on patient and
14 physician regret in the surgical
15 setting." See that?

16 A. I do.

17 Q. Now look at "Results." See
18 that?

19 A. I'm there now, yes.

20 Q. It says, "Of 889 studies
21 identified, 73 patient studies and 6
22 physician studies met inclusion
23 criteria." Do you see that?

1 A. I'm reading it now, yes.

2 Q. I understand this is a
3 systematic review of 73 patient studies
4 and 6 physician studies on regret and
5 surgical decision-making; right?

6 A. That's what it says here, yes.

7 Q. Then the third sentence of
8 "Results" says, "Interestingly
9 self-reported patient regret was
10 relatively uncommon with an average
11 prevalence across studies of 14.4%."
12 Right?

13 A. Right.

14 Q. And then "Conclusion" says,
15 "Self-reported decisional regret was
16 present in about 1 in 7 surgical
17 patients." You see that?

18 A. I do.

19 Q. All right. So according to this
20 systematic review, one out of seven
21 surgical patients, on average, report
22 having decisional regret; correct?

23 MR. KNEPPER: Objection, form.

1 A. Right. So actually, I would go
2 a little deeper than that. The first
3 thing to note about this study -- and
4 again, this is my first reading of it, so
5 I'm on the fly here.

6 The first thing to note about it
7 is that they looked at nearly 900
8 studies, of which only 73 qualified as
9 having sufficient validity to include in
10 their study. So this -- this speaks to a
11 problem in the literature. I'd have to
12 read lower to see what particular -- if
13 they even examined what kind of surgeries
14 were performed, because regret can happen
15 for a number of reasons, including
16 postsurgical complications and so on,
17 types of surgery.

18 Q. We don't need --

19 A. Yeah.

20 Q. We don't need to dig into this
21 too deeply. But, I mean, you don't
22 dispute that regret is not uncommon for
23 patients who have any kind of surgical

1 procedure; right?

2 MR. KNEPPER: Objection to form.

3 A. No. You know, there's --
4 there's -- it's such a life-changing
5 event that the potential for regret is
6 very high, so that's why you have to be
7 careful in consenting the patient.

8 Q. Okay. Let me -- let's go back
9 to your report.

10 A. Okay.

11 Q. Because I hear you criticizing
12 all this evidence, and I want to see the
13 stuff that you're relying on. Go to page
14 22.

15 A. All right.

16 Q. All right. About halfway down
17 this paragraph, you say, "As reported by
18 one author in 2021, 60,000 testimonies of
19 personal de-transition can be found on
20 the Internet."

21 A. Yeah, that's a typo. That's a
22 typo. That should have been 16, not 60.

23 Q. Okay. Well, I think it's more

1 than that.

2 A. Okay.

3 Q. So we'll look at this in a
4 second.

5 A. Sure, sure.

6 Q. And you cited this article from
7 Pablo Exposito-Campos.

8 A. Yes.

9 Q. E-X-P-O-S-I-T-O, dash,
10 C-A-M-P-O-S. Right? That's what you
11 rely on; right?

12 A. Not relying. I'm basically just
13 putting that out there as an example of a
14 growing number of patients regretting
15 transitioning, yeah.

16 Q. Well, no. What you say in your
17 report is that according to this
18 publication, you can find 60,000 -- or
19 let's call it 16,000 testimonies of
20 personal de-transition on the Internet;
21 right? That's the point you're making?

22 A. Sixteen thousand, right. Yeah.

23 Q. Let's look at what that article

1 actually says.

2 A. Okay.

3 Q. Okay. This is going to be
4 Exhibit 22. And let me know when you get
5 it.

6 A. Doesn't seem to be coming
7 through.

8 Q. Yeah, it may be stuck on my end.
9 Okay. Just went through, so you should
10 see it shortly.

11 (Exhibit 22 was marked for identification
12 and is attached.)

13 A. There it is. Okay. Right.

14 Q. All right. This is the article
15 that you're citing in your report; right?

16 A. Uh-huh.

17 Q. All right. So before we get
18 there, you know that what this author was
19 talking about was a Reddit website;
20 right?

21 A. Yeah. That was -- that was
22 their data source, yeah. Right.

23 Q. Reddit is not a peer-reviewed

1 publication, obviously; right?

2 A. Clearly.

3 MR. KNEPPER: Objection.

4 A. Yeah.

5 Q. Right?

6 A. Yes. It's not a peer-reviewed.

7 Q. It's a social website that

8 anyone can access; right?

9 A. Right. Correct.

10 Q. Anyone can post -- can register
11 an account on Reddit and post whatever
12 they want; right?

13 A. Right.

14 Q. A post on Reddit is not
15 something that you would consider
16 reliable scientific evidence, I assume;
17 right?

18 A. Yeah, no.

19 MR. KNEPPER: Objection, form.

20 A. I would -- I would put that as
21 self-reporting anecdotal-level evidence,
22 that's right. So it's -- it's not
23 definitive, but it's suggestive of an

1 area in need of examination. And that's
2 the reason I include it here, is not as
3 definitive evidence of a particular level
4 of problem but the -- the presence of a
5 problem that needs to be addressed. So
6 the substance of my testimony there where
7 I call this study up is to show that
8 there's a growing body of patients, as we
9 talked about earlier, a growing body of
10 patients who regret their transition and
11 are seeking reversal. So that's what
12 this is about.

13 It's not a quantification of the
14 phenomenon. It's not a level 3 evidence
15 of the phenomenon. It's a level 5,
16 self-reported, anecdotal stuff that --
17 that is basically just calling us to look
18 more carefully at what promises to be a
19 controversial area of medical care. So
20 this is just part -- part of the
21 controversy is what we're looking at
22 here. We're not looking at a definitive
23 scientific document, so.

1 Q. It's not even level 5 because at
2 least a case report that's published in a
3 peer-reviewed journal has someone looking
4 at that case report to figure out if it's
5 a real thing; right?

6 A. Right.

7 MR. KNEPPER: Objection, form.

8 A. What we have here is a clinical
9 psychologist who's looking at something
10 going on online, and the clinical
11 psychologist is -- is reporting this,
12 that's right.

13 Q. Go to page 4 of this article.

14 A. One, two, three, four. Okay.

15 Q. See there's a second paragraph
16 under "Further clarifications"?

17 A. Yes, I do.

18 Q. All right. And it references
19 this Reddit/detrans subreddit; right?

20 A. Right.

21 Q. And it says it's "a subreddit
22 for detransitioners to share their
23 experiences with more than 16,000

1 members."

2 A. That's correct.

3 Q. Right?

4 A. Uh-huh.

5 Q. Then it says, "one can find
6 several stories of people who call their
7 transgender status into question." You
8 see that?

9 A. Right.

10 Q. All right. This author is not
11 saying that there's 16,000 separate
12 testimonies of people tran- --
13 detransitioning on that subreddit; right?

14 A. I think the author is saying
15 that there's a pool of 16,000 people
16 among whom are evidence of regret or
17 cessation of transition. That's what --
18 I think that's what the author's saying.

19 Q. Well, let's be more specific,
20 because what he actually says is "one can
21 find several stories." Right?

22 A. Right.

23 Q. There's a very big difference

1 between, quote, several stories and
2 16,000 stories of detransitioning; right?

3 A. I think what the author is
4 saying is that -- that there are -- let's
5 see. Subreddit -- detran--
6 experiences -- more than 16- -- one can
7 find several stories of a particular kind
8 of transgender -- persons who call their
9 transgender status into question after
10 stopping transition.

11 So the several stories have to
12 do with people who call their transgender
13 status into question. Not people who
14 regret the surgery, but these are people
15 who regret the diagnosis. So he's
16 talking about several stories of
17 regretters of the diagnosis. It doesn't
18 speak about regretters of the transition.
19 He doesn't address that in that.

20 Q. All right. A bunch of posts on
21 a social website is not scientifically
22 reliable evidence to show the number of
23 different people who actually

1 detransition; right, Doctor?

2 MR. KNEPPER: Form.

3 A. Yeah. As we said before, we
4 have no way of -- at present, of knowing
5 the number of people.

6 Q. Okay. Go back to your report.

7 A. Okay.

8 Q. Go to page 40.

9 A. All right. Okay.

10 Q. All right. Your first paragraph
11 at the top of this page says, "A
12 currently unknown percent--
13 "percentage and number of patients
14 reporting gender dysphoria are being
15 manipulated by a -- peer group, social
16 media, YouTube role modeling, and/or
17 parental -- social contagion and social
18 pressure processes." Right?

19 A. That's right.

20 Q. I take it you're not aware of
21 any peer-reviewed studies that quantifies
22 the number of people with gender
23 dysphoria that are being, quote, unquote,

1 manipulated by social contagion or social
2 pressure; right?

3 A. Again, as I said before, we
4 don't know the numbers because that's not
5 -- it's not adequately reported in the
6 literature. But what we do know is that
7 the social -- Lisa Littman's article, for
8 example, in 2017 shows us that there's a
9 significant factor in this new
10 demographic of self-reported transgender
11 patients, the new demographic being
12 adolescent to young adult females without
13 prior history of gender dysphoria or
14 gender discordance suddenly reporting
15 transgender self-identification.

16 And -- and what it shows us,
17 what Lisa -- Lisa Littman's publication
18 from Brown University shows us is that
19 underlying these outbreaks is peer group
20 networks of people online, peer groups
21 online, social media, a modeled speech, a
22 rehearsed speech, and -- and these --
23 these sudden outbreaks of -- of

1 self-identified transgender patients.
2
3 So we know it's there, but we
4 can't quantify it yet. It's just it's --
5 but it's -- we have at present no other
6 explanation for why the demographic of
7 self-reported transgender patients has
8 suddenly shifted from virtually all young
9 boys to 50 to 60 percent of the new cases
being adolescent to young adult females.
10 And that's -- that's what we're -- what
11 we're talking about here. This just
12 speaks to the controversial nature of
13 this -- medical and surgical
14 interventions is that we don't even
15 understand the origin of that phenomenon.
16 And -- and what that Littman article
17 shows us is precisely these things: that
18 there's an element of social contagion,
19 that there's peer pressure, there's
20 rehearsed speech, online networks that
cause these outbreaks of these new kind
21 of patients, adolescent young adult
22 females who previously had no

1 self-reporting of trans- -- cross-sex
2 self-identification.

3 MR. TISHYEVICH: This is not
4 responsive to my question, and I move to
5 strike it.

6 Q. Here's my question, Doctor. You
7 are not aware of any peer-reviewed study
8 that quantifies the number of people with
9 gender dysphoria who are being
10 manipulated by social contagion or social
11 pressure; correct?

12 A. No. We're at the -- we're at
13 the level of level 4/5 evidence now.
14 Lisa Littman's article is a level 5,
15 possibly 4. A level 5. So --

16 Q. It's not a -- you're also not
17 aware of any peer-reviewed study that
18 quantifies the percentage of people with
19 gender dysphoria who are being
20 manipulated by social contagion or social
21 pressure; correct?

22 A. No. That's part of the -- part
23 of the problem with the literature.

1 Exactly right.

2 Q. Yeah.

3 A. Exactly right.

4 Q. Given this lack of reliable
5 studies, do you agree that this
6 phenomenon of social contagion is
7 currently hypothetical?

8 MR. KNEPPER: Objection, form.

9 A. I would not agree with that.
10 It's not hypothetical.

11 Q. Do you -- did you read the
12 response from Lisa -- from Littman to the
13 criticisms to that article?

14 A. I did. And -- and I also noted
15 that the -- the -- the organization under
16 which she published that article put
17 considerable pressure on her. But she
18 can't retract her data. She can retract
19 her conclusions, but she can't retract
20 her data, and she can't retract the
21 findings in the paper itself that show
22 the rehearsed speech, that show the
23 networks that are involved, that showed

1 the -- the character of the -- the
2 rehearsed speech, like, you know, if
3 you're talking to the psychologist, tell
4 them you've been thinking about suicide;
5 if you're talking to the endocrinologist,
6 tell them you feel better now that you're
7 started on T, that sort of stuff. So --
8 so it's not hypothetical, it's actual.

9 The -- the size of the
10 phenomenon can only be compared to the
11 change in the demographic. Why are 60
12 percent of patients fitting into that
13 category suddenly, whereas before, only
14 20 percent of patients were females?

15 Q. Do you remember --

16 A. That's what --

17 Q. Okay. Do you remember the part
18 of the correction from Ms. Littman where
19 she said that this is a
20 hypothesis-generating article?

21 A. Hypothesis as to -- as to
22 mechanism of -- of action, and some of
23 the hypotheses are what's listed there:

1 social network peer -- media -- I'm
2 sorry -- peer pressure, social media,
3 role modeling, social contagion. So she
4 admits that is a -- it is not understood.
5 She admits that those phenomena are
6 there, but it -- at present, we're
7 hypothesizing about the actual cause.
8 And this speaks again to the
9 controversial nature of even the
10 diagnosis, much less the treatment.

11 Q. Go back to your report.

12 A. Okay.

13 Q. Page 40.

14 A. I'm there.

15 Q. Toward the bottom, you say, in
16 capital letters, "Not Generally
17 Accepted." You see that?

18 A. I do.

19 Q. And you say, "Affirmation
20 medical treatments -- hormones and
21 surgery -- for gender dysphoria and
22 transitioning have not been accepted by
23 the relevant scientific communities." Do

1 | you see that?

2 A. I do.

3 Q. It's your expert opinion that
4 it's generally accepted that puberty
5 blockers are not medically necessary;
6 right?

7 A. N.O.

8 MR. KNEPPER: Objection, form.

9 A. I would say puberty blockers in
10 the setting of a self-identified
11 transgender is not medically necessary,
12 but puberty blockers are often medically
13 necessary, just not in that particular
14 patient population.

15 Q. Is it also your expert opinion
16 that it's generally accepted that hormone
17 treatment for gender dysphoria is not
18 medically necessary?

19 A. Well, the scientific evidence
20 now shows that it is -- is not useful.
21 That's what I said --

Q. Answer my question. Is it your expert opinion that it's generally

1 accepted that hormone treatment for
2 gender dysphoria is not medically
3 necessary?

4 A. Yes.

5 Q. Is it also your expert opinion
6 that it's generally accepted that
7 gender-affirming surgery for gender
8 dysphoria is not medically necessary?

9 A. Yes. I would say so, yeah. I
10 can't put a number on it, but yeah.

11 Q. All right. Let me -- let me
12 show you another document. Okay. Let me
13 introduce this. Okay. This is going to
14 be Exhibit 23. And let me know when you
15 get it.

16 (Exhibit 23 was marked for identification
17 and is attached.)

18 A. Okay. All right. I'm there.

19 Q. Okay. Top of the page says,
20 "BlueCross BlueShield of North Carolina."
21 Right?

22 A. Correct.

23 Q. You know what Blue Cross and

1 Blue Shield is; right?

2 A. Right.

3 Q. It's a healthcare insurer;
4 right?

5 A. Yes.

6 Q. Are you aware that Blue Cross
7 Blue Shield is the largest private
8 insurer in the state of North Carolina?

9 A. I am now.

10 MR. KNEPPER: Objection, form.

11 Q. All right. This document is
12 titled "Corporate Medical Policy,"
13 "Gender Affirmation Surgery and Hormone
14 Therapy." Right?

15 A. Right.

16 Q. Do you know what this is?

17 A. Do I know what what is?

18 Q. Do you know what this document
19 is?

20 A. It appears to be an insurance
21 company document concerning the coverage
22 of certain services. I would have to
23 read it to know what it is specifically,

1 but I think it's probably a policy
2 statement about what is covered and what
3 is not covered and what the diagnostic
4 criteria are.

5 Q. Yeah.

6 A. What the policy of the company
7 is. Yeah. So, shall I read it or?

8 Q. I'll walk you through it.

9 A. Okay.

10 Q. You see it says "Last Review"
11 near the top?

12 A. Right.

13 Q. It's 3/2021. That's March 2021;
14 right?

15 A. Yes.

16 Q. All right. You understand this
17 policy was a -- strike that.

18 In your report, you cite a
19 number of articles that you say Dr. Brown
20 and Dr. Schechter overlooked, like a
21 bunch of 2020 articles; right?

22 A. Right.

23 Q. You understand this was

1 published -- updated after all those
2 studies that you cited were published;
3 right?

4 A. It appears to be.

5 Q. Okay. Go to page 7. You see it
6 says "Scientific Background and Reference
7 Sources"?

8 A. Right.

9 Q. You understand this section of
10 the policy provides some of the
11 scientific background on which the policy
12 is based; right?

13 A. I see that, yes.

14 Q. And if you go to page -- the
15 next page, page 8, you see there's a
16 bunch of references to Specialty Matched
17 Consultant Advisory Panel; right?

18 A. I see that, yeah.

19 Q. And there's some references to
20 sen- -- Senior Medical Director reviews;
21 right?

22 A. I see that, yeah, from 2016.

23 Q. Yeah. Well, if you keep

1 looking, there's a bunch from 2020;
2 right?

3 A. I see medical director review in
4 2020. Yes, I do. I see that.

5 Q. And then including a medical
6 director review in March 2021; right?

7 A. I see it. That's probably what
8 generated this document. Am I right?

9 Q. Yeah. Good guess. Now,
10 obviously --

11 A. That's why they pay me the big
12 bucks. Sorry.

13 Q. Obviously, you had no
14 involvement with the development of this
15 policy from BlueCross BlueShield of North
16 Carolina; right?

17 A. Correct.

18 Q. You have no idea how BlueCross
19 BlueShield of North Carolina came to
20 decide what gender affirmation surgeries
21 or hormone therapy they're going to cover
22 or not; right?

23 A. Wrong. I -- I have now some

1 idea of what they used because you've
2 listed -- or they've listed the
3 scientific background and reference
4 sources for coming to their company
5 policy. And what I would point you to is
6 the fact that every one of the documents,
7 the scientific documents that support
8 their decision-making, I think the most
9 recent one is 2014. You've got some that
10 go back to the year 2000. So you've got
11 21-year-old DSM-4 characterizations.
12 You've got 2001 Harry Benjamin Gender
13 Dysphoria Association publications. The
14 most recent thing is a -- is a -- well,
15 that's actually an advisory panel. So
16 the most recent medical article is the
17 Cohen-Kettenis Hembree article from 2016.
18 So what's used to support a March 2021
19 document is essentially six-year-old
20 information. And as we talked about
21 earlier, it hasn't -- it's changed a lot.
22 It's changed a lot since then.

23 The fact that Blue Cross Blue

1 Shield is slow off the mark would be
2 troublesome to the shareholders, I
3 suppose. But as far as what I'm here to
4 talk about, the scientific basis for
5 this, the scientific basis is old data.

6 Q. Doctor, you don't know whether
7 this is an exhaustive list of every
8 scientific resource that Blue Cross Blue
9 Shield considered in making the March
10 2021 update; right? You have no idea?

11 MR. KNEPPER: Objection, form.

12 A. I can only go by what they've
13 disclosed.

14 Q. Right.

15 A. And what they've disclosed --
16 which I would assume they would be
17 leading with their best information
18 rather than their worst -- I would call
19 that -- the scientific support of low
20 quality because of the -- the
21 better-quality data that's now available
22 in the last three years.

23 Q. You don't know personally

1 whether Blue Cross Blue Shield considered
2 any of the articles that you've cited
3 when they're making this policy change in
4 2021; right? You don't know that?

5 A. I have no way of knowing how --

6 Q. Yeah.

7 A. -- that committee worked. I
8 only -- I only assume that they would
9 have put out their best scientific
10 support rather than their weakest.

11 Q. Yeah. Bottom of this page, by
12 the way, see there's a section that says,
13 "Policy Implementation/Update
14 Information"?

15 A. Yes, I see that.

16 Q. And it says, "7/19/11" --

17 A. Yeah.

18 Q. -- "New policy developed."
19 Right?

20 A. Right.

21 Q. You understand that Blue Cross
22 Blue Shield has had some form of this
23 policy for gender affirmation surgery

1 since July 2011?

2 MR. KNEPPER: Objection, form.

3 A. I can see that they have had a
4 policy, according to their own reporting,
5 since July of 2011.

6 Q. All right. So, let's look at
7 what Blue Cross Blue -- Blue Cross Blue
8 Shield thinks about whether these
9 procedures are medically necessary. Go
10 to page 5.

11 A. Let's see. So we're at page 8.
12 We're going up to page 5? Okay. Okay.

13 Q. Give me a second. Actually, let
14 me start you on page 1. You see there's
15 a description of -- let me know when you
16 get there.

17 A. I'm there.

18 Q. Okay. Now, the beginning says,
19 "Gender Dysphoria is the formal diagnosis
20 used by professionals to describe persons
21 who experience significant gender
22 dysphoria (discontent with their
23 biological sex and/or birth gender)."

1 Right?

2 A. Yes, I see that.

3 Q. All right. You understand what
4 this policy is addressing; right?

5 A. Yeah. It's addressing a
6 psychiatric classification, not medically
7 classified as a medical illness. So
8 they're -- yeah.

9 Q. Okay. Go to page 2.

10 A. Can you give me just a moment to
11 reread that sentence for just a second.

12 (Witness reviews document.)

13 A. Okay. Yeah. So that's
14 boilerplate. I'm sorry. Sorry for
15 slowing you down here.

16 Q. That's fine. Go to page 2.

17 A. Okay.

18 Q. Top of the page says, "Policy."
19 Right?

20 A. Correct.

21 Q. And it says, "Services for
22 gender affirmation surgery and hormone
23 therapy may be considered medically

1 necessary when the criteria below are
2 met." You see that?

3 A. Right. So that's -- that's
4 language that insurance companies use.
5 If you're not in the category of medical
6 necessity, there's no insurance coverage.
7 So whether or not one could classify it
8 as a medical diagnosis is not at issue.
9 What's at issue is, is the insurance
10 company going to cover this -- this
11 benefit.

12 Q. Yeah. Because insurers
13 typically are not in the business of
14 covering services that are not medically
15 necessary; right?

16 A. No. I wouldn't --

17 MR. KNEPPER: Objection, form.

18 A. -- characterize it that way.

19 THE WITNESS: I'm sorry.

20 A. I wouldn't characterize it that
21 way. Insurance companies are in the
22 business of -- certainly, they're in the
23 business of -- of paying for covered

1 benefits. But that's the problem with
2 the insurance industry, is their primary
3 fiduciary duty is to their investors.
4 And so the question of coverage has more
5 to do with are we going to make an
6 insurance policy that earns us money or
7 are we going to be paying for something
8 and not seeing the money. Okay? Does
9 that make sense?

10 Q. Doctor, you --

11 A. I think that's what -- that's
12 what this language here is talking about
13 is -- is medical necessity is the
14 language that's used when an insurance
15 company will cover. They will not cover
16 cosmetic surgery, but they're -- they're
17 proposing to cover transgender surgery
18 beginning by attempting to define it as a
19 medical diagnosis. That's what's at
20 stake here is.

21 Q. No. What -- what this policy
22 says is that when certain criteria are
23 met --

1 A. Right.

2 Q. -- gender affirmation surgery
3 and hormone therapy may be considered
4 medically necessary; right? That's what
5 it says in black and white.

6 MR. KNEPPER: Objection, form.

7 A. Yeah, again, so medically
8 necessary from the standpoint of an
9 insurance company is if you meet these
10 criteria, we'll pay for it; if you don't
11 meet these criteria, we won't pay for it.
12 That's -- that's --

13 Q. Right. And the difference is
14 whether the surgery is considered to be
15 medically necessary or not; right?

16 MR. KNEPPER: Objection, form.

17 A. Well, again, so medically
18 necessary in this case is has the
19 insurance company decided that they're
20 going to cover this benefit. It says
21 nothing about the scientific support for
22 the efficacy of the procedure. They
23 haven't said anything in that about it.

1 They've just called it medically
2 necessary.

3 Q. All right. Let's -- let's go
4 off the record.

5 A. Okay.

6 THE VIDEOGRAPHER: This is the
7 end of Media Unit No. 5. We are off the
8 record at 3:25 p.m.

9 (Break taken.)

10 THE VIDEOGRAPHER: This is the
11 beginning of Media Unit No. 6. We are on
12 the record at 3:36 p.m.

13 Q. (By Mr. Tishyevich) All right.
14 I'm going to introduce another exhibit,
15 Doctor.

16 A. Okay.

17 Q. It's being slow on my end. Bear
18 with me. Okay. This will be Exhibit 24.
19 Let me know when you have it.

20 (Exhibit 24 was marked for identification
21 and is attached.)

22 A. I will. Okay. I've got it.

23 Q. Okay. You've seen this study

1 before; right?

2 A. Yes, I have.

3 Q. How do you pronounce the lead
4 author's name?

5 A. That's the subject of great
6 debate, but I think it's Dhejne or -- I
7 think it's Dhejne, Cecilia Dhejne, but
8 I -- I -- I'm not -- I'm not a
9 Swissophone.

10 Q. I'll use Dhejne as well.

11 A. Okay.

12 MR. TISHYEVICH: And for the
13 court reporter, it's D-H-E-J-N-E.

14 Q. Okay. This is a study from
15 2011; right?

16 A. Yes.

17 Q. And you cited this study in
18 several places in your report --

19 A. I do.

20 Q. -- right?

21 And one of the points for which
22 you cite this study is to say that
23 Swedish patients who underwent

1 gender-affirming surgery had a 19.1 times
2 greater suicide rate than the control
3 group; right?

4 A. Yeah. The hazard ratio for --
5 well, for all reassigned persons is 19.1,
6 and they further break out the -- that
7 into subgroups of female-to-male and
8 male-to-female.

9 Q. Yeah. And you understand how
10 the control group in this study was
11 defined; right?

12 A. Yes.

13 Q. The control group did not
14 consist of patients with gender dysphoria
15 who did not undergo gender-affirming
16 surgery; correct?

17 A. Correct.

18 Q. The control group consisted of
19 patients without gender dysphoria; right?

20 A. Yeah. That's kind of the point
21 of the -- of the research, yes. That's
22 right.

23 Q. Yeah. What this Dhejne study

1 compared was the suicide rate for
2 patients who underwent gender-affirming
3 surgery against the general Swedish
4 population; right?

5 A. Right.

6 Q. And you know there's many
7 studies that find that patients with
8 gender dysphoria, as a population, have a
9 higher risk of suicide compared to the
10 general population; right?

11 A. Very much accepted fact, yes.

12 Q. Yeah. All right. We'll go to
13 page 7.

14 A. Let's see here.

15 Q. You see there's a "Strengths and
16 limitations of the study" section?

17 A. Two, three, four, five, six,
18 seven. Yes, I'm there.

19 Q. All right. Look at the third
20 full paragraph in that column.

21 A. Okay.

22 Q. All right. Second sentence
23 says: "The caveat with this design is

1 that transsexual persons before sex
2 reassignment might differ from healthy
3 controls (although this bias can be
4 statistically corrected for by adjusting
5 for baseline differences). It is
6 therefore important to note that the
7 current study is only informative with
8 respect to transsexual persons health
9 after sex reassignment; no inferences can
10 be drawn as to the effectiveness of sex
11 reassignment as a treatment for
12 transsexualism."

13 You see that?

14 A. Right. Yeah.

15 Q. Then it says: "In other words,
16 the results should not be interpreted
17 such as sex reassignment per se increases
18 morbidity and mortality. Things might
19 have been even worse without sex
20 reassignment." Correct?

21 A. Yeah. It's -- the -- let's see.
22 The -- yeah, so -- and I don't think I
23 ever make the claim that the surgery

1 increases the risk of morbidity and
2 mortality. Yeah, I -- I would agree with
3 that.

4 Q. Yeah, no --

5 A. But I would -- I would also
6 wonder on what basis they -- there's
7 nothing to support that it might have
8 been worse either. It's for the same
9 reason.

10 Q. Yeah. This study does not
11 support the conclusion that sex
12 reassignment surgery by itself increases
13 risk of suicide; correct?

14 A. That's what they -- they say,
15 yes.

16 Q. And they also say that this
17 study does not support the conclusion
18 that surgical procedure for gender
19 dysphoria by themselves increase risk of
20 morbidity other than suicide; right?

21 A. Right.

22 Q. Okay. All right. Let me -- you
23 mentioned that -- in your report the 2020

1 Finland guidelines. You recall that?

2 A. I do.

3 Q. Let me ask you a couple of
4 questions on those.

5 A. Okay.

6 Q. So I'll introduce another
7 exhibit. This will be Exhibit 25, and
8 let me know when you get it.

9 (Exhibit 25 was marked for identification
10 and is attached.)

11 A. Okay.

12 Q. Let me ask you before we get
13 into this, look at page 46 of your
14 report.

15 A. Okay.

16 Q. Near the top, there's a "2020 -
17 Finland" reference. You see that?

18 A. I see that, yeah.

19 Q. You say, "This new Finnish
20 guidance prioritizes psychological
21 therapy over treatment with hormones or
22 surgery and suggests different care plans
23 for early-onset vs late-onset childhood

1 gender dysphoria." You see that?

2 A. I do.

3 Q. And then you say in the last
4 sentence, "The Finland National
5 Guidelines appear quite contrary to the
6 opinions of Drs Brown and Schechter and
7 WPATH." Do you see that?

8 A. I do.

9 Q. Is it your opinion that the
10 WPATH guidelines recommend that children
11 who experience gender dysphoria should
12 transition to a different gender role?

13 MR. KNEPPER: Objection, form.

14 A. No. I would say that the WPATH
15 guidelines essentially leaves us with
16 affirmation care only, that it does -- it
17 does, you know, recom- -- recommend all
18 of the psychological support but all of
19 it in support of transition. I would say
20 that. Yeah.

21 Q. Yeah. The WPATH guidelines do
22 not recommend that children with gender
23 dysphoria automatically be put on puberty

1 blockers; right?

2 A. They don't make that
3 recommendation, no. They don't state
4 that recommendation, no.

5 Q. Yeah. Let's look at what they
6 actually say.

7 A. Okay.

8 Q. I'm going to introduce one more
9 exhibit.

10 A. So we're going to leave the
11 Finland article for now and go to --

12 Q. Yeah. We'll come back to it. I
13 want to show you the WPATH --

14 A. Okay.

15 Q. -- Standards of Care Version 7
16 first.

17 A. Uh-huh.

18 Q. All right. This will be Exhibit
19 26. Let me know when you have it.

20 (Exhibit 26 was marked for identification
21 and is attached.)

22 A. Okay.

23 Q. This is a larger file, so this

1 may take an extra minute or so.

2 A. Okay. I've got it.

3 Q. Okay. These are the WPATH
4 Standards of Care Version 7; right?

5 A. Yes.

6 Q. Turn to page 23.

7 A. Okay.

8 Q. All right. There's a section
9 titled "Social Transition in Early
10 Childhood." You see that?

11 A. I must be on the wrong page.

12 Did you say page 23?

13 Q. It's PDF page 23, which is going
14 to be page 17 in the standards.

15 A. Oh, I'm sorry. Okay. Let's go
16 back, then. Page 17. Okay. I'm there.
17 Right. "Social Transition in Early
18 Childhood."

19 Q. All right. It says: "Some
20 children state that they want to make a
21 social transition to a different gender
22 role long before puberty. For some
23 children, this may reflect an expression

1 of their gender identity. For others,
2 this could be motivated by other forces."

3 You see that?

4 A. I do.

5 Q. And then a couple of sentences
6 down, it says: "This is a controversial
7 issue, and divergent views are held by
8 health professionals. The current
9 evidence base is insufficient to predict
10 the long-term outcomes of completing a
11 gender role transition during early
12 childhood." You see that?

13 A. I do.

14 Q. All right. The WPATH Standards
15 of Care Version 7 is not making any
16 clinical recommendations encouraging
17 children in early childhood to go through
18 gender transition roles; correct?

19 A. Yeah, I would -- yes. I would
20 add to that that they're also not
21 offering any clinical guidance on how to
22 distinguish who might or who might not be
23 suitable for transition. Right.

1 Q. Do you know whether that's
2 explored somewhere else in this Standards
3 of Care Version 7?

4 A. Yeah. I think it's discussed.

5 Q. Okay.

6 A. But -- but it's -- but I --
7 yeah. So what's -- what's important, I
8 think, in what you cite here is that the
9 current evidence base is insufficient to
10 predict the long-term outcome. Yes.

11 Q. Okay. Go to the next page.

12 A. Okay.

13 Q. Page 18, PDF page 24.

14 A. Okay.

15 Q. There's a section titled
16 "Physical Interventions for Adolescents."

17 A. Right.

18 Q. Right?

19 A. Yes.

20 Q. You understand that adolescents
21 are different than children; right?

22 MR. KNEPPER: Objection, form.

23 A. Well, yeah. So, adolescents are

treated in pediatric clinics, but they're
different from prepubertal children, yes.

3 Q. Yeah. This section does not
4 provide any clinical recommendations for
5 hormone therapy in prepubescent children;
6 right?

7 A. Let's see. I've just got to
8 refresh my memory here on the verbiage.

9 (Witness reviews document.)

10 A. Yeah. So it -- it addresses the
11 important issue of gender fluidity in
12 adolescents, potential for shift to
13 conformity and -- that may not persist.
14 Yeah. Right.

15 Q. Okay. And this section also
16 does not provide any clin- -- clinical
17 recommendations for surgical intervention
18 in prepubescent children; right?

19 A. This section doesn't address
20 prepubescent children. It addresses
21 adolescents.

Q. Yeah, exactly. And you don't know of any other section in these

1 Standards of Care Version 7 that provide
2 those guidelines for prepubescent
3 children; right?

4 A. No.

5 Q. Okay. Go to the next page, PDF
6 page 25, page 19 in the document.

7 A. Okay.

8 Q. And you see there's a section
9 that says, "Criteria for
10 Puberty-Suppressing Hormones"?

11 A. Yes.

12 Q. It says, "In order for
13 adolescents to receive
14 puberty-suppressing hormones, the
15 following minimum criteria must be met."
16 You see that?

17 A. Yes.

18 Q. And then there's four items;
19 right?

20 A. Yes.

21 Q. Number 4 says, "The adolescent
22 has given informed consent and,
23 particularly when the adolescent has not

1 reached the age of medical consent, the
2 parents or other caretakers or guardians
3 have consented to the treatment and are
4 involved in supporting the adolescents
5 throughout the treatment process."

6 You see that?

7 A. Yeah. That -- in fact, that was
8 one of the most troubling things I read
9 when I reviewed this whole document from
10 the WPATH guidelines, is that -- yeah,
11 that using those words in the same
12 sentence, an adolescent giving informed
13 consent, is a -- is a non sequitur
14 because I -- I don't think -- in all my
15 years of practice as a surgeon, which
16 amounts to greater than 35, the idea of
17 obtaining consent from an adolescent was
18 never accepted by the surgical community
19 or the medical community, to my
20 understanding.

21 Q. Well, this also talks about
22 getting informed consent from the parents
23 or other caretakers or guardians; right?

1 A. Yeah. So in their role
2 supporting the adolescent's decision. It
3 doesn't say -- yeah. So the parents or
4 other caregivers have consented in
5 support. Right.

6 Q. Yeah. What the guidelines
7 contemplate is that it's not just the
8 adolescent that's going to give an
9 informed consent, it's also the parents
10 or other caretakers or guardians; right?

11 A. Yeah. But again, that's the
12 problem I have with it, because that's --
13 the introductory sentence has -- has no
14 meaning -- or the introductory part of
15 the one sentence has no meaning. If the
16 beginning point of the process is
17 adolescent consent, that's -- that's not
18 an ethical thing to do because --

19 Q. Yeah.

20 A. -- because an adolescent can't
21 grasp -- they don't have enough executive
22 function or development, particularly if
23 they have been through a period of

1 puberty suppression before they begin the
2 period of cross-sex hormones, that it's
3 -- it's already quite evident that these
4 patients, these children do not have
5 enough -- and it's just known in society
6 at large that adolescent children don't
7 have the capacity for long-term reckoning
8 of things like risk and outcomes and
9 neither do they have the executive
10 capacity in their brains to make an
11 informed consent decision. So that part
12 of it is meaningless to me. Yeah.

13 Q. Yeah. But you understand
14 there's two components to this
15 requirement; one is informed consent by
16 the adolescent, and two is informed
17 consent by parents or other caretakers or
18 guardians. Right?

19 A. Yes.

20 Q. Okay.

21 A. That's what it says.

22 Q. All right. Let's now go back to
23 the Finland guidelines. It's Exhibit 25.

1 A. Okay.

2 Q. And go to PDF page 9 which has
3 Section 8, "Summary" -- "Summary of the
4 Recommendations." Let me know when you
5 get there.

6 A. Okay.

7 Q. All right. This page provides
8 recommendations for treatment of minors
9 with gender dysphoria in Finland; right?

10 A. Yes.

11 Q. All right. Look at number 2 at
12 the bottom.

13 A. At the bottom. Okay. Okay.

14 Q. All right. So it starts with,
15 "If a child is diagnosed prior to the
16 onset of puberty with a persistent
17 experience of identifying as the other
18 sex and shows symptoms of gender-related
19 anxiety, which increases in severity in
20 puberty." You see that?

21 A. Yes, I do.

22 Q. All right. And then next
23 sentence says, "Based on these

1 assessments, puberty suppression
2 treatment may be initiated on a
3 case-by-case basis after careful
4 consideration and appropriate diagnostic
5 examinations if the medical indications
6 for the treatment are present and there
7 are no contraindications."

8 Do you see that?

9 A. I do.

10 Q. All right. You understand that
11 these Finland guidelines do not
12 categorically prohibit the use of
13 puberty-blocking agents in minors;
14 correct?

15 MR. KNEPPER: Objection, form.

16 A. Right. They don't
17 categorically, but what they do is they
18 express uncertainty about the data that
19 -- that's been used to support the use of
20 those drugs in children.

21 Q. Yeah. But -- but despite that
22 data, what the guidelines recognize is
23 that puberty-blocking treatment may still

1 be initiated for some minor patients in
2 certain circumstances.

3 A. Right.

4 Q. Right?

5 A. Agree.

6 MR. KNEPPER: Objection, form.

7 Q. All right. Let's go back to
8 your report. Go to page 46.

9 A. I'm there.

10 Q. So in your discussion of these
11 Finland guidelines, you cite something
12 called -- it's a website,
13 genderreport.ca.

14 A. Correct.

15 Q. Do you see that?

16 A. I do.

17 Q. And I saw at least two other
18 references to this source in your report.
19 All right. This is -- genderreport is
20 not a peer-reviewed publication, Doctor;
21 right?

22 A. No. It's a data collection
23 site. Yeah.

1 Q. It's a data collection site?

2 A. I think that's what the -- so,
3 let me just review what I wrote here.

4 (Witness reviews document.)

5 A. All right. Okay. Yeah. Okay.
6 Yeah, no. I agree they're not
7 peer-reviewed to my knowledge, no.

8 Q. It's a blog; right?

9 A. Right. It's on -- it's online,
10 exactly.

11 Q. Blogs are not generally
12 considered reliable scientific evidence,
13 I take it. Right?

14 MR. KNEPPER: Objection, form.

15 A. No, they're not.

16 Q. Okay. Do you know who started
17 this genderreport blog?

18 A. I do not.

19 Q. Do you know this person was a
20 doctor?

21 A. I don't know the person, no.

22 Q. You don't know they're a
23 scientist?

1 A. I 'm sorry?

2 Q. You don't know whether they're a
3 scientist; right?

4 A. I don't know.

5 Q. Did you know that this blog was
6 started by a parent who was upset that
7 her daughter was told in school that
8 girls are not real and who filed a
9 lawsuit about it?

10 MR. KNEPPER: Objection, form.

11 A. I did not know those details,
12 no.

13 Q. Assuming that's true, do you
14 think this is an unbiased, objective
15 resource?

16 MR. KNEPPER: Objection to form.

17 A. I -- I don't know. I don't know
18 the answer to that question.

19 Q. Do other experts in your field
20 rely on blogs like this one to support
21 their opinions?

22 MR. KNEPPER: Objection, form.

23 A. And I don't, and neither did I

1 rely on this as sole support for my
2 opinion. This -- again, this is just
3 evidence of -- of controversy that exists
4 out in the literature, or that exists out
5 in the -- in the greater world, I should
6 say, in this case because this is not
7 medical literature, but in the wider
8 world.

9 Q. Well, as I read this, your page
10 46, you're -- you're citing this gender
11 report for your analysis of the 2020
12 Finland guidelines.

13 MR. KNEPPER: Objection, form.

14 Q. Right?

15 A. I think I'm using the Finland
16 guidelines as a standalone and just
17 referencing this gender report as
18 evidence of events in Finland rather than
19 scientific support for the conclusions of
20 the Finland review.

21 Q. Okay. Another article you cite
22 is the Carmichael 2021 study.

23 A. Right.

1 Q. Let's look at that one. I'll
2 introduce it as Exhibit 27. Let me know
3 when you have that.

4 (Exhibit 27 was marked for identification
5 and is attached.)

6 A. Okay. Okay. I have it.

7 Q. Okay. This is titled,
8 "Short-Term outcomes of pubertal
9 suppression in a selected cohort of 12 to
10 15 year old young people with persistent
11 gender dysphoria in the UK."

12 A. Right.

13 Q. Right?

14 A. Yeah.

15 Q. All right. Look at the -- on
16 page 1, you see there's an abstract?

17 A. Yes.

18 Q. Under "Methods," it says, "We
19 undertook an uncontrolled prospective
20 observational study." Right? Do you see
21 that?

22 A. Right.

23 Q. All right. This is not a

1 randomly controlled clinical trial;
2 right?

3 A. Right.

4 Q. Not a cohort study --

5 A. Right.

6 Q. -- right?

7 A. Right.

8 Q. There's no control group; right?

9 A. Correct.

10 Q. You don't mention any of that in
11 your report even though you spend a lot
12 of time discussing the limitations of
13 other studies. Why is that?

14 MR. KNEPPER: Objection, form.

15 A. I -- we include this to one to
16 show the raging controversy in the world
17 of transgender medicine, and this is an
18 example of that, the -- the evidence of
19 uncertain result or no result, no change
20 from baseline effect.

21 Let's see. Let me just review
22 because I've reviewed so many of these
23 articles lately.

(Witness reviews document.)

A. Right. Yeah. So -- yeah. So that's right. So they were unable to quantify benefit or harm from puberty suppression.

Q. Go to page 21. See there's a "Strength and Limitations" section?

A. I see it. Yes, I do.

Q. The second sentence says: "The study size and uncontrolled design were key limitations. The small sample size limited our ability to identify small changes in outcomes. This was an uncontrolled observational study and thus cannot infer causality." See that?

A. I do.

Q. Again, you don't acknowledge any of these limitations in your report; right?

MR. KNEPPER: Objection, form.

A. Right. I believe I made reference to this in terms of it's evidence of -- of controversy in the

1 literature, that they could not see a
2 benefit from it. So again, at lower
3 levels of evidence, evidence of benefit
4 would suggest further study. This shows
5 that further study is needed because, at
6 the observational level, you don't see
7 effect.

8 Q. All right. Another study -- not
9 a study, a review that you cite is this
10 Cochrane 2020 --

11 A. Yes.

12 Q. -- review; right?

13 A. Right.

14 MR. TISHYEVICH: And for the
15 court reporter, that's C-O-C-H-R-A-N-E.

16 Q. I'm going to introduce that one
17 next.

18 A. Okay.

19 Q. All right. I'm introducing this
20 as Exhibit 28, and let me know when you
21 get it.

22 (Exhibit 28 was marked for identification
23 and is attached.)

1 A. I will. Okay.

2 Q. Okay. This is from the Cochrane
3 Library. This is the review that you
4 cite in your report; right?

5 A. Right.

6 Q. Go to page 2.

7 A. Okay.

8 Q. All right. You see there's the
9 section titled, "Authors' Conclusions"?

10 A. Okay. Yes, I do.

11 Q. All right. Toward the end, do
12 you see it says, "We will include
13 non-controlled cohort studies in the next
14 iteration of this review, as our review
15 has shown that such studies provide the
16 highest quality evidence currently
17 available in the field." You see that?

18 A. Yes, I do.

19 Q. All right. So the Cochrane
20 review is not saying they're just going
21 to ignore all those studies going
22 forward; right?

23 A. Right.

1 MR. KNEPPER: Objection, form.

2 Q. They rec- -- they recognize that
3 those noncontrolled studies currently
4 represent the best available evidence;
5 right?

6 MR. KNEPPER: Objection, form.

7 A. Well, yeah. Before they say
8 best available evidence, they speak about
9 the level of the evidence now. And
10 what's -- what's interesting about this
11 Cochrane review, because it's a worldwide
12 review of the literature on the subject
13 of cross-sex hormones and hormone
14 blockade in transwomen, is that they
15 found over a thousand references, and by
16 the time they got through qualifying
17 those references for suitability, they
18 got down to thirteen studies. And when
19 they fully screened the text, they got
20 down to a single study. And that's --
21 that's kind of characteristic of -- of
22 the data used to support hormonal
23 transitioning.

1 And so yeah, they -- they have
2 to -- they have to backpedal in order to
3 get any data because what they have in
4 hand now is -- is not supportive of -- of
5 the use of cross-sex hormones in
6 transwomen, so.

7 Q. All right. Let me introduce
8 another exhibit.

9 MR. TISHYEVICH: Can we go off
10 the record?

11 THE VIDEOGRAPHER: We are off
12 the record at 4:07 p.m.

13 (Break taken.)

14 THE VIDEOGRAPHER: We are back
15 on the record at 4:20 p.m.

16 Q. (By Mr. Tishyevich) All right.
17 Doctor, let me ask you about what
18 experience you have with the individual
19 plaintiffs in this case specifically.

20 You personally did not meet with
21 any of the plaintiffs in this case;
22 correct?

23 A. No. I did a review of their

1 charts and nothing more. Yeah.

2 Q. All right. You've personally
3 never spoken with any of the plaintiffs;
4 correct?

5 A. I have not.

6 Q. You obviously were not present
7 in any meetings that any of these
8 plaintiffs may have had with their mental
9 health professionals; right?

10 A. I was not.

11 Q. And you don't know specifically
12 what was said or not said during those
13 meetings; correct?

14 A. The only information I have
15 about those meetings was what's entered
16 in the medical record that was given to
17 me to review.

18 Q. Yeah. You were also not present
19 in any meetings any of the plaintiffs may
20 have had with their endocrinologists;
21 right?

22 A. Correct.

23 Q. And outside of reading medical

1 records, you don't know what was said or
2 not said during those meetings; correct?

3 A. Correct.

4 Q. And finally, for plaintiffs who
5 had undergone surgical procedures, you
6 were also not present in any meetings
7 between these plaintiffs and their
8 surgeons; correct?

9 A. Correct.

10 Q. And outside of medical records,
11 again, you don't know what was said or
12 not said during those meetings; correct?

13 A. Correct.

14 Q. Okay. You should see a new
15 exhibit pop up, Exhibit 29.

16 A. Okay.

17 (Exhibit 29 was marked for identification
18 and is attached.)

19 Q. And if you can go to PDF page
20 54.

21 A. PDF page 54. Okay.

22 Q. First of all, you understand
23 what this document is; right?

1 A. I didn't get to see the header
2 on it. I haven't seen this before, I
3 don't think.

4 Q. Oh, feel free -- yeah, feel free
5 to go back to the first page if you want
6 to.

7 A. Okay.

8 (Witness reviews document.)

9 Q. All right. This is the --

10 A. Okay. Okay. So it's --

11 Q. Yeah.

12 A. -- a benefits booklet for the
13 State health plan. Is that right?

14 Q. For North Carolina, right.

15 A. Yes. The teachers union --
16 teachers and employ- -- and State
17 employees, right. Okay.

18 Q. You know what a benefit plan is;
19 right?

20 A. Yes, uh-huh.

21 Q. At a high level, it sets out
22 what the insurer is going to cover or not
23 cover; right?

1 A. Correct.

2 Q. Among other things. Okay. And
3 earlier, we talked about medical
4 necessity. You recall that?

5 A. Yes.

6 Q. All right. Go to -- now go back
7 to PDF page 54 of this plan.

8 A. Okay. I'm there.

9 Q. You see at the top, it says,
10 "What is not Covered?" And it's a list
11 of items?

12 A. Am I on the right page? I'm
13 on -- on PDF page 54?

14 Q. Yeah.

15 A. That's the -- the -- oh, I'm
16 sorry.

17 Q. Plan page 46, so that's --

18 A. Plan page 46. Let me back up
19 real quickly here. Sorry. Okay. I'm
20 there.

21 Q. At the top or near the top, it
22 says, "What is not Covered?" You see
23 that?

1 A. I do.

2 Q. There's a list of items
3 alphabetically. See that?

4 A. Yes.

5 Q. And under M, it says, "Services
6 or supplies deemed not medically
7 necessary." "Medically necessary" is in
8 bold; right?

9 A. Right.

10 Q. All right. Let's look at that
11 definition. Go to PDF page 89, which is
12 page 81 of the plan.

13 A. Okay.

14 Q. All right. At the bottom, you
15 see there's a definition of "Medically
16 Necessary (or Medical Necessity"; right?

17 A. Yes.

18 Q. And it says, "those covered
19 services or supplies that are: a)
20 Provided for the diagnosis, treatment,
21 cure, or relief of a health condition,
22 illness, injury, or disease; and, except
23 for clinical trials as described under

1 this health benefit plan, not for
2 experimental, investigational, or
3 cosmetic purposes." Right?

4 A. Okay.

5 Q. I understand that as part of
6 determining what the benefit plan is
7 going to consider medically necessary,
8 whether or not the treatment is
9 experimental is one of the factors;
10 right?

11 A. As would be defined -- so all of
12 the definitions here are determined by
13 the insurance provider. So they've
14 defined these listed necessities as
15 covered under their plan, yes.

16 Q. Yeah. So under this definition,
17 if a treatment is experimental, it is
18 likely not going to be covered under the
19 plan; right?

20 A. Right. According to their
21 definition, it doesn't appear they would
22 cover experimental surgery or cosmetic
23 surgery.

1 Q. Conversely, if a treatment is
2 not experimental, it may be covered by
3 the plan in some circumstances; right?
4

5 A. It would seem --
6

7 MR. KNEPPER: Objection, form.
8

9 Q. Yeah. And I showed you earlier
10 a policy from BlueCross BlueShield of
11 North Carolina from March 2021 that says
12 that gender-affirming hormone and
13 surgical treatment is considered
14 medically necessary; right?
15

16 MR. KNEPPER: Objection, form.
17

18 A. Yeah, no. As we talked about
19 before, these are definitions formulated
20 by the insurance company to define
21 coverage, not medical definitions in
22 terms of medical care. This is strictly
23 coverage by insurance. Yeah.

24 Q. Well, one of the factors that
25 goes into that consideration is whether
26 or not that treatment in question is
27 experimental; right?
28

29 MR. KNEPPER: Objection, form.
30

1 A. Right. The plan excludes
2 experimental or investigational or
3 cosmetic procedures.

4 Q. Okay. All right. We're talking
5 about BlueCross BlueShield of North
6 Carolina. Let me ask you about another
7 insurer, Aetna, A-E-T-N-A. You've heard
8 of Aetna; right?

9 A. Yes.

10 Q. Are you aware that Aetna is one
11 of the five largest health insurance --
12 insurers in the U.S.?

13 A. It would not surprise me to
14 learn that.

15 MR. KNEPPER: Form.

16 Q. Do you have any idea whether
17 Aetna considers gender-affirming surgery
18 and hormone therapy to be medically
19 necessary?

20 MR. KNEPPER: Objection, form,
21 scope.

22 Q. Would it surprise you if Aetna
23 --

1 THE COURT REPORTER: I'm sorry.
2 I didn't hear the answer over the
3 objection.

4 THE WITNESS: I haven't answered
5 yet.

6 THE COURT REPORTER: Okay.

7 THE WITNESS: Sorry.

8 A. So as to the size of Aetna or
9 the -- that they cover --

10 Q. Yeah, let me just ask -- I'll
11 ask the question again.

12 A. Okay.

13 Q. Do you have any idea whether
14 Aetna considers gender-affirming surgery
15 and hormone therapy to be medically
16 necessary?

17 MR. KNEPPER: Objection, form,
18 scope.

19 A. I don't.

20 Q. Well, let me show you. I'm
21 going to introduce another exhibit.
22 Okay. This is going to be Exhibit 30.
23 Let me know when you have it.

1 (Exhibit 30 was marked for identification
2 and is attached.)

3 A. Okay. All right. I have it.

4 Q. All right. This is a policy
5 from Aetna titled "Gender Affirming
6 Surgery." You see that?

7 A. I do.

8 Q. You see there's a "Policy
9 History" on the right?

10 A. Yes.

11 Q. Under "Last Review," it says
12 January 12th, 2021; right?

13 A. Yes.

14 Q. So you understand this was
15 revised within this year; right?

16 A. Yes.

17 Q. And under Policy, it says,
18 "Aetna considers gender affirming surgery
19 medically necessary when all of the
20 following criteria are met." Right?

21 A. Right.

22 MR. KNEPPER: Form.

23 Q. All right. So according to this

1 policy, in Aetna's view, gender-affirming
2 surgery is medically necessary, therefore
3 nonexperimental; right?

4 MR. KNEPPER: Objection, form.

5 A. Yeah, Aetna's definition of what
6 is medically necessary appears to allow
7 for gender-affirming surgery.

8 Q. Okay. Go to page 3.

9 A. Okay.

10 Q. Look at the bottom of the page.

11 A. Okay.

12 Q. The second to the last paragraph
13 says, "Aetna considers
14 gonadotropin-releasing hormone medically
15 necessary to suppress puberty in trans
16 identified adolescents if they meet World
17 Professional Association for Transgender
18 Health (WPATH) criteria." Do you see
19 that?

20 A. I do.

21 Q. Okay. According to Aetna,
22 puberty-blocking hormones are medically
23 necessary to suppress puberty in

trans-identified adolescents if they meet
the WPATH criteria; right?

3 MR. KNEPPER: Objection, form.

4 A. That -- that's what it states
5 there, yes.

6 Q. By the way, look at the next
7 paragraph. See it says, "Aetna considers
8 reversal of gender affirming surgery for
9 gender dysphoria not medically
10 necessary."

11 MR. KNEPPER: Objection.

Q. Do you see that?

13 A. I do.

14 Q. Okay. We talked about Blue
15 Cross Blue Shield, talked about Aetna.
16 Do you know what Cigna is?

17 A. Yeah. It's one of the largest
18 health insurance providers.

19 Q. Do you know what position Cigna
20 takes on whether gender dysphoria
21 treatment is medically necessary?

22 MR. KNEPPER: Objection, form,
23 scope.

1 A. I have not read their policies.

2 Q. You don't know; right?

3 A. Correct.

4 Q. Let me show you that policy.

5 A. Okay.

6 Q. All right. This is going to be
7 Exhibit 31. Let me know when you have
8 it.

9 (Exhibit 31 was marked for identification
10 and is attached.)

11 A. Okay. Okay. I have it.

12 Q. All right. This is a Cigna
13 medical coverage policy titled "Treatment
14 of Gender Dysphoria." Do you see that?

15 A. Yes, I do.

16 Q. On the right top, it says
17 "Effective Date," May 18th, 2021; right?

18 A. Yes.

19 Q. Also recently updated; right?

20 A. Yes.

21 Q. Go to page 2. Under "Coverage
22 Policy," look at the third paragraph in
23 bold. It says, "Medically necessary

1 treatment for an individual with gender
2 dysphoria may include any of the
3 following services, when services are
4 available in the benefit plan." Do you
5 see that?

6 A. I do.

7 Q. All right. And then there's
8 five different bullets of different
9 categories of services; right?

10 A. One, two, three, four, five.

11 Yes.

12 Q. Number two is "Hormonal therapy,
13 including but not limited to androgens,
14 anti-androgens, Gn- -- "GnRH analogues,
15 estrogens, and progestins." Right?

16 A. Yes.

17 Q. That's a medically necessary
18 benefit in Cigna's view; right?

19 MR. KNEPPER: Objection, form.

20 A. It is a -- medically necessary
21 as defined by a insurance company for
22 purposes of a policy.

23 Q. Yeah.

1 A. Yes.

2 Q. And the last bullet point says,
3 "Gender reassignment and related surgery
4 (see below)." Do you see that?

5 A. I do.

6 Q. According to this policy, in
7 Cigna's view, gender reassignment and
8 related surgery is a medically necessary
9 service; right?

10 MR. KNEPPER: Objection, form.

11 A. Again, so -- so the insurance
12 company makes a distinction between
13 medically necessary, meaning things that
14 they will cover, versus not medically
15 necessary, meaning things they won't
16 cover. It's not based on an actual
17 medical diagnosis but a -- a managerial
18 diagnosis, because if it's not medically
19 necessary, it's not covered by insurance.
20 So if they choose to cover it, they will
21 call that medically necessary. And
22 that's what they're detailing here, what
23 they will cover and what they won't

1 cover.

2 Q. Okay.

3 A. And they call what they will
4 cover medically necessary.

5 Q. Let me show you one last policy.
6 Do you know -- strike that.

7 You know what UnitedHealthcare
8 is; right?

9 A. Yes, I do.

10 Q. It's another health insurer;
11 right?

12 A. Yes.

13 Q. They're the largest health
14 insurer in the country; right?

15 A. I don't know that for a fact.
16 I'll assume if you're telling me so.

17 Q. All right. Well, do you have
18 any idea whether United considers
19 gender-affirming surgery and hormone
20 treatment to be medically necessary for
21 gender dysphoria?

22 A. I have a dawning suspicion that
23 they do.

1 Q. Yeah. I think you can probably
2 tell where this is heading at this point;
3 right?

4 A. Sure. The insurance industry
5 likes these services.

6 Q. Let me introduce this next
7 exhibit. This is going to be Exhibit 32.
8 All right at the top it says, "United
9 Healthcare." You see that?
10 (Exhibit 32 was marked for identification
11 and is attached.)

12 A. I don't have it yet.

13 Q. Oh, I apologize.

14 A. That's okay.

15 Q. Let me know when.

16 A. Okay. Yes.

17 Q. All right. Top right says
18 "United Healthcare" -- "Healthcare
19 Commercial Medical Policy." Right?

20 A. Yes.

21 Q. Under that, it says, "Gender
22 Dysphoria Treatment." Right?

23 A. Yes.

1 Q. See there's an effective date of
2 April 1, 2021; right?
3

4 A. Yes.
5

6 Q. Also fairly recently updated;
7 right?
8

9 A. Yes.
10

11 Q. Okay. And then you see there's
12 a bunch of bullet points setting forth
13 criteria for the services on page 1;
14 right?
15

16 A. Yeah. Yes.
17

18 Q. Then go to page 2.
19

20 A. Okay.
21

22 Q. And the first full paragraph
23 says, "When the above criteria are met,
24 the following surgical procedures to
25 treat Gender Dysphoria are medically
26 necessary and covered as a proven
27 benefit." Do you see that?
28

29 A. I do.
30

31 Q. Okay. So United also covers --
32 also considers this treatment to be
33 medically necessary; right?
34

1 MR. KNEPPER: Objection to form.

2 A. Yeah, again, so the interesting
3 thing about this that I'm just reading --
4 because, again, this is the first time
5 I've seen this -- is that the same policy
6 declares that the policy does not apply
7 to individuals with objectively ambiguous
8 genitalia or disorders of sexual
9 development. So that's an example of the
10 insurance company choosing what to call
11 medically necessary based upon an
12 insurance definition rather than a
13 medical definition. Because under, you
14 know, plastic surgical/general medical
15 wisdom, ambiguous genitalia and disorders
16 of sexual development are objective
17 medical surgical -- well, medical
18 conditions, at least, that would be
19 covered -- would be considered medically
20 necessary to treat, you know, because
21 disorders of sexual development can
22 include emergencies like adrenal
23 hyperplasia. So that's a -- you've given

1 an example of how insurance companies
2 make their own definitions for the sake
3 of distinguishing what they will cover
4 and what they will not cover.

5 Q. Go to page 9.

6 A. Okay.

7 Q. You see there's a section toward
8 the bottom that says, "Benefit
9 Considerations"?

10 A. Yes.

11 Q. Third paragraph says, "Unless
12 otherwise specified, if a plan covers
13 treatment for Gender Dysphoria, coverage
14 includes psychotherapy, cross-sex hormone
15 therapy, puberty suppressing medications
16 and laboratory testing to monitor the
17 safety of hormone therapy." Do you see
18 that?

19 A. I do.

20 Q. You understand that United
21 considers not just surgery but all these
22 other services, including cross-sex
23 hormone therapy and puberty suppressing

1 medications, to be medic- -- medically
2 necessary for the treatment of gender
3 dysphoria; right?

4 MR. KNEPPER: Objection, form,
5 scope.

6 A. Yeah, again, the same -- same
7 issues of definition. So they -- they
8 can define it any way they choose for the
9 sake of the business of insuring people,
10 yeah. So they -- they definitely have
11 defined all of the services associated
12 with gender dysphoria as covered
13 benefits.

14 Q. And not just as covered
15 benefits, as medically necessary; right?

16 A. Again --

17 MR. KNEPPER: Objection, form
18 and scope.

19 A. Again, they use -- the use of
20 the word "medically necessary" is defined
21 by the insurance company to distinguish
22 covered benefits from not covered
23 benefits, and it's not based in medical

1 evidence of efficacy or anything else.
2 It's just an internal definition for the
3 sake of their business model.

4 Q. You think that insurers do not
5 look at scientific literature in deciding
6 whether or not to cover something?

7 MR. KNEPPER: Objection, form.

8 Q. Is that really what you think?

9 A. Your -- your first example that
10 we've gone through is a -- is an example
11 of the level of literature they've been
12 using, and that example showed that the
13 most recent paper that they used to
14 support it was 2016. So in my mind, it's
15 in doubt. I don't know for a fact what
16 this particular policy used as
17 references. All I have is what you've
18 shown me on that particular policy. And
19 the evidence there was they're not
20 current in the -- in the literature. But
21 they're still doing good business,
22 apparently, because they continue even
23 after reviewing.

1 Q. Okay. Go to page 10.

2 A. Okay. All right.

3 Q. See there's a section at the
4 bottom that says, "Clinical Evidence"?

5 A. Yes.

6 Q. Do you know what that means?

7 A. Yes, I do.

8 Q. You see then the first thing
9 that's said -- cited is a study from 2019
10 and the second thing is a study from
11 2019, the third thing is a study from
12 2019. You see that?

13 A. I do.

14 MR. KNEPPER: Objection, form.

15 Q. Do you under- -- do you
16 understand what this section represents?

17 MR. KNEPPER: Objection, form.

18 A. Permit me to just look at the
19 particular names and the particular cited
20 articles, if I could.

21 (Witness reviews document.)

22 A. Sorry. I just wanted to see if
23 there were any -- and then they go to --

1 okay. Okay. Could I ask you to ask your
2 question again? I'm sorry to have to do
3 that. I just wanted to see what you were
4 referring to.

5 Q. Yeah. You understand that this
6 "Clinical Evidence" section provides an
7 overview of some of the scientific
8 evidence on which United based its
9 policy; right?

10 MR. KNEPPER: Objection, form.

11 A. Yes. They -- they have listed
12 some of the scientific evidence available
13 in the literature.

14 Q. Including studies as recently as
15 2019 --

16 A. Yes.

17 Q. -- right?

18 A. Right.

19 Q. And because you weren't involved
20 with writing this policy or updating for
21 United, you don't know what else they may
22 have considered outside of this policy;
23 right?

1 A. I have no way of knowing what
2 they would have considered. That's
3 right.

4 Q. Okay. All right. Let's shift
5 gears a little bit. You've heard the
6 term "Christian anthropology." Right?

7 A. Yes, I have.

8 Q. You've used that term yourself;
9 right?

10 A. Yes, I have.

11 Q. The view that Christian
12 anthropology takes is that the -- a
13 person's sex assigned at birth is
14 intrinsic and unchangeable; correct?

15 A. No.

16 MR. KNEPPER: Objection, form,
17 scope.

18 A. I would not say that.

19 Q. What would you -- how would you
20 describe it?

21 A. Well, your use of the term "sex
22 assigned at birth" is not -- is not
23 contained within Christian anthropology.

1 Q. Let me try this --

2 A. By the -- by the way, I don't --
3 I don't use definitions in Christian
4 anthropology to confect my expert
5 opinion. My opinion is based in the
6 scientific literature, my review of that
7 literature, and my 30-plus years'
8 experience as a reconstructive surgeon.

9 Q. I understand. The view that
10 Christian -- to use your words, the view
11 that Christian anthropology takes is that
12 a person's biologic sex is intrinsic and
13 unchangeable; right?

14 A. Yes.

15 MR. KNEPPER: Objection, form,
16 scope.

17 Q. You think that people with
18 gender dysphoria should be welcomed, but
19 they should be told that they're
20 biological sex cannot be changed; right?

21 MR. KNEPPER: Objection, form,
22 scope.

23 A. Yeah. So, persons who

1 self-identify as transgender are to be
2 welcomed and are to be cared for because
3 they suffer greatly, and they -- they
4 deserve, in justice -- they deserve, out
5 of justice, I should say, our -- our care
6 and support. But that care and support
7 must always be rooted in the truth of the
8 nature of the human person, the nature of
9 the biology that informs our
10 understanding of that, because that has
11 to drive our medical and surgical
12 decision-making.

13 So that's why my -- my expert
14 opinion is based in the objective
15 scientific evidence. I don't make
16 reference to my -- any faith statements
17 when I'm -- when I'm developing my expert
18 opinion on transgender medicine and
19 surgery.

20 Q. In your expert report, you refer
21 to plaintiff Julie -- Dr. Julie McKeown;
22 right?

23 A. Could you walk me to where I

1 speak about her?

2 Q. Yeah. Go to -- go to page 54 of
3 your report.

4 A. Fifty-four. Thank you.

5 MR. TISHYEVICH: And the
6 spelling is M-C-K-E-O-W-N.

7 A. Fifty-four. Okay. I'm there.

8 Q. Give me a second. Yeah. This
9 is -- this is you discussing one of the
10 plaintiffs; right?

11 A. Yes. Yes. I'm on page 53, 54.

12 Q. Yeah. And the second full
13 paragraph on page 54, you refer to Dr.
14 McKeown as a he; right?

15 (Witness reviews document.)

16 A. Am I looking at the right -- oh,
17 yes. Okay. I'm sorry. Right at the
18 very beginning. Yes.

19 Q. Page 48 of your report, this is
20 you discussing minor plaintiff CB; right?

21 A. Right.

22 Q. And you refer to minor plaintiff
23 as a she; right?

1 A. Correct.

2 Q. Go to page 51.

3 A. Fifty-one?

4 Q. Five one.

5 A. Okay. All right.

6 Q. This is you talking about

7 plaintiff Connor Thonen-Fleck; right?

8 A. Let me go to the preceding page
9 because I've got to see where the names
10 -- oh, I only used the initials. Yes.

11 CT-F, yes.

12 Q. It's T-H-O-N-E-N, dash,
13 F-L-E-C-K. And you refer to him as a
14 she; right?

15 A. Yes.

16 Q. Now, you personally do not
17 believe that a person's sex assigned at
18 birth can ever be changed?

19 MR. KNEPPER: Objection.

20 Q. Sorry, let me -- let me use your
21 terms. You personally do not believe
22 that a person's biological sex can ever
23 be changed; right?

1 MR. KNEPPER: Objection, form.

2 A. A person's biological sex can
3 never be changed, yes.

4 Q. Do you know what the term
5 "misgendering" is?

6 A. It's a -- it's a political term,
7 yes. It's a political, cultural term, I
8 should say. Political, cultural term.

9 Q. Misgendering means referring to
10 a person in a way that doesn't align with
11 their gender; right?

12 MR. KNEPPER: Objection, form.

13 A. In -- within their hearing, I
14 could see a problem with that. But from
15 the standpoint of offering medical
16 evidence, I'm obliged to honor objective
17 biological realities when I speak about
18 an examination of their medical record.

19 There's so many things at stake
20 relating to the sex of the patient that
21 impinge upon the effects of drugs, the
22 effects of time, the effects of hormones
23 that I -- I cannot incorrectly report the

1 sex of the patient when I'm talking about
2 objective medical care.

3 Now, speaking with the patients
4 themselves, I wouldn't do that. As we
5 talked about earlier, I have a number of
6 transgender patients, and I don't
7 misgender them. We're talking here about
8 something that's not within their hearing
9 or I assume they -- I assume that they
10 wouldn't be reading this. We're speaking
11 as a professional to a professional
12 review of this stuff, among other
13 experts. So I think it's essential that
14 we stick to the biological reality that
15 -- that biological sex is immutable.

16 Q. In your expert report, you are
17 misgendering several of the individual
18 plaintiffs in this case; correct?

19 MR. KNEPPER: Objection, form.

20 A. I would say incorrect, because
21 misgendering is something that's done to
22 the person themselves or is something
23 that they're going to read or hear or

1 see. And that's an abuse of the person's
2 right to their name, and I don't do that
3 to people. I don't misgender people.

4 Q. Well, in this report at least,
5 you are referring to several of these
6 plaintiffs, including a minor, in a way
7 that does not align with their gender;
8 right?

9 A. I would be --

10 MR. KNEPPER: Objection, form.

11 A. Again, I would be concerned to
12 not do that if it was going to be
13 something they were going to read or
14 hear. But this expert testimony, in my
15 understanding, is for the Court and for
16 the other experts to review, in which
17 case, I insist upon the -- the prevailing
18 necessity of sticking to objective truths
19 when talking about medical opinions,
20 scientific opinions.

21 Again, I -- I'm not in the habit
22 of -- of offending people or using names
23 that they haven't chosen, because, again,

1 I treat transgender patients and I don't
2 subject them to that kind of abuse. But
3 when reviewing medical and biological
4 realities like this, I have to insist
5 upon it because medical care is not
6 served by incorrectly naming biological
7 realities and confusing people. I can
8 give you an example if you like.

9 Q. That's all right.

10 A. Of a --

11 Q. That's all right.

12 A. Okay.

13 Q. You've used the phrase before,
14 "You can't heal an interior wound with
15 external surgery." Right?

16 A. Yes, I have.

17 Q. Do you remember giving a
18 presentation at the Gospel of Life
19 conference in Denver in 2018?

20 A. Yes.

21 Q. And that presentation was titled
22 "Transgender Surgery & Christian
23 Anthropology." Right?

1 A. Yes.

2 Q. All right. Let me introduce an
3 exhibit. This will be Exhibit 33. Let
4 me know when you have it.

5 (Exhibit 33 was marked for identification
6 and is attached.)

7 A. Okay. Yes, I have it.

8 Q. Go to page 2.

9 A. Okay.

10 Q. These are slides you prepared;
11 right?

12 A. Yes.

13 Q. On the bottom left corner,
14 there's a red logo for Courage
15 International. You see that?

16 A. I do.

17 Q. Why did you include that logo in
18 this presentation?

19 MR. KNEPPER: Objection, form,
20 scope.

21 A. This was a presentation for the
22 Archdiocese of Denver, the Catholic
23 Archdiocese of Denver, and it was to an

1 audience of pastors, teachers, school
2 administrators, and so on. And I was
3 there representing my position in the
4 Catholic apostolate of courage, and so
5 making a presentation to a church group,
6 I wanted them to understand the resource
7 so that they could investigate it
8 themselves if they wanted to. So I put
9 that up there for their benefit.

10 Q. Well, some of the topics you
11 covered also included your views on what
12 the scientific evidence on these issues
13 is; right?

14 A. Yeah. The -- the talk is a
15 combination of both the scientific
16 evidence and the historic Catholic
17 teachings on the nature of the human
18 person.

19 Q. For example, go to page -- go to
20 page 87, for example.

21 A. Okay. Let me hustle down there.
22 Boy, no wonder people get bored when I
23 give this talk. It's so long; right?

1 Let's see. 87. Here we are. Is that --
2 let's see. This is -- I want to make
3 sure I'm on the same page as you are.
4 It's of the --

5 Q. It's titled "The Swedish
6 Study" --

7 A. Yes.

8 Q. -- at the top.

9 A. Yes, yes.

10 Q. And go to the next page.

11 A. Okay. Yeah.

12 Q. You cite from the abstract on
13 that study; right?

14 A. Yes. Well, I -- I'm not citing
15 it. I'm showing them what this study
16 looks like if they search for it online.

17 Q. So part of the talk was your
18 recitation of what you think the
19 scientific evidence on these issues
20 shows; right?

21 MR. KNEPPER: Objection, form,
22 scope.

23 A. Yeah, I was asked to talk on

1 this -- on -- on both subjects, as I said
2 earlier, both the -- the teaching in
3 human anthropology as well as the
4 scientific evidence that's used to
5 support these services of transgender
6 medicine and surgery. That's right.

7 Q. Courage International is an
8 organization that offers support for
9 persons who experience same-sex
10 attraction; right?

11 A. Yes.

12 MR. KNEPPER: Objection, form,
13 scope.

14 Q. Courage International says that
15 people should not act on same sex
16 attraction and should strive for chastity
17 instead; right?

18 MR. KNEPPER: Objection, form,
19 scope.

20 A. Actually, it's broader than
21 that. So, Courage addresses chastity as
22 something that's required of everyone.
23 But it -- it particularly addresses the

1 struggles that persons who experience
2 same-sex attraction experience in trying
3 to maintain the same chastity that all of
4 us are called to. So it's not an
5 exceptional case; it's a particular
6 apostolate to a particular group of
7 people.

8 Q. There's a chapter of Courage
9 International in Birmingham, Alabama;
10 right?

11 A. That's correct.

12 MR. KNEPPER: Objection, form,
13 scope.

14 Q. And their website lists you as
15 the main contact for that chapter; right?

16 A. I'm not only the contact, I'm
17 the chaplain for that chapter.

18 Q. Okay. Go to page 3 of this
19 presentation.

20 A. Okay.

21 Q. Let me know when you get there.

22 A. Okay. Two, three. Yes. The
23 Challenge?

1 Q. It's titled "The Challenge"?

2 A. Yeah.

3 Q. The first bullet says, "'Male
4 and female He created them.'" Right?

5 A. Right.

6 Q. That's a quote from Genesis;
7 right?

8 A. Correct.

9 Q. The capitalized "He" refers to
10 God; right?

11 A. Yes.

12 Q. And this bullet reflects the
13 church's position that God has created
14 each individual as either a man or a
15 woman; right?

16 A. Well, actually, so this -- these
17 slides serve as jumping-off points for a
18 discussion that I have at each slide. In
19 this case, the point of the discussion
20 was to disabuse the audience of the idea
21 that they can rely on scripture when
22 addressing this problem because the
23 majority of the people that are seeking

1 to serve do not speak in Biblical
2 language. So the point of this slide is
3 to -- is to encourage them to understand
4 that they have to learn a new language in
5 order to be able to speak effectively to
6 people suffering from gender discordance
7 and to speak to their families on this
8 same issue. That's what this slide is
9 about. It's not a -- it's not a
10 declaration about what God has said.
11 It's a -- it's an explanation of the
12 problem they're going to have if they're
13 going to seek to serve people who
14 experience same-sex -- I'm sorry, who
15 experience cross-sex identification.

16 Q. All right. You say, "'Male and
17 female He created them' has been replaced
18 by a confusion of exceptional cases."
19 Right?

20 A. Yes.

21 Q. And by the phrase "confusion of
22 exceptional cases," one of the things
23 you're referring to are patients with

1 gender dysphoria; right?

2 MR. KNEPPER: Objection, form,
3 scope.

4 A. Right. I'm referring to the --
5 the recently growing list of exceptional
6 cases that is enumerated in the -- the
7 acronyms of -- of this topic, LGBTQ add a
8 plus and so on, which can be very
9 confusing to people who are trying to
10 help. And so I'm acknowledging that the
11 -- the likelihood that they may be
12 confused by those terms, and I'm also
13 acknowledging the sources of those
14 confusing terms. And the point of the
15 slide, again, is to help them understand
16 there's a language they need to learn and
17 to not be daunted by the confusion that
18 they may experience when they first look
19 into this topic. Yeah. That's what this
20 is.

21 Q. Go to slide 11. It's titled
22 "Human Nature."

23 A. So slide 11, Human Nature, yes.

1 Okay.

2 Q. So the first two bullets say,
3 "Why must we consider first the nature of
4 the human person?" Then it says,
5 "Defines the 'end' of medical and
6 surgical care."

7 A. Yes.

8 Q. What does it mean that it
9 "defines the 'end' of medical and
10 surgical care"?

11 MR. KNEPPER: Objection, form,
12 scope.

13 A. Okay. So that's a -- that's a
14 term that dates back to Aristotelian
15 philosophy. And what it has to do is
16 what is the purpose or what is the
17 ultimate arc of a particular thing. So
18 the "end" meaning what are you seeking to
19 accomplish, what is the final goal of
20 that -- of that medical or surgical
21 treatment.

22 So -- and the examples I use are
23 you have to have an understanding, for

1 example, of normal blood pressure in
2 order to know when to treat it and why
3 normalizing blood pressure is important.
4 Or we have to know that, you know, the
5 human person has two legs, and if he has
6 a poverty of legs, he has a poverty of
7 human flourishing. And so in the one
8 case, I might be treating with blood
9 pressure medicine, and in the other case,
10 I might be fitting him for a prosthesis.
11 But the point is we have an objective
12 understanding of the nature of the human
13 person, which defines the goals of
14 treatment, whether you're talking about
15 orthopedics or transgender medicine.

16 Q. Yeah. You think this concept
17 also applies to the concept of treatment
18 for gender dysphoria; right?

19 A. It does. Yes, it does.

20 MR. KNEPPER: Objection, form,
21 scope.

22 Q. All right. Go to slide 23.

23 A. Okay. Okay.

1 Q. The top left says, "Shaping the
2 Conversation, & Grooming a Generation."

3 A. Right.

4 Q. You see that?

5 A. Right.

6 Q. What do you mean by "grooming a
7 generation"?

8 A. Grooming is a -- is a process by
9 which ideas are introduced that make
10 subsequent actions possible, so that's
11 what -- that's what grooming is, yeah.

12 Q. Grooming is sometimes used to
13 refer to preparing to -- strike that.

14 Grooming is sometimes used as
15 preparing children for sexual abuse.
16 Isn't that true?

17 A. That's one of the --

18 MR. KNEPPER: Objection, form,
19 scope.

20 A. That's one of the uses of
21 grooming, yeah, but it's not exclusive
22 use of grooming. Yeah. And I discuss
23 this in this -- in this slide. Yes, I

1 do.

2 Q. And you think that discussing
3 gender identity issues with children
4 means sexualizing them; right?

5 A. Yes, I do. Absolutely, I do.

6 MR. KNEPPER: Objection, form,
7 scope.

8 Q. And you think that discussing
9 gender identity issues with children
10 means grooming them for potential later
11 sexual abuse; right?

12 MR. KNEPPER: Objection, form,
13 scope.

14 A. No. No. What we're talking
15 about here is grooming them for -- for
16 future -- what's the word I would want to
17 choose carefully? It's preparing them
18 for these interventions is what it does.
19 It lays the groundwork for it by
20 sexualizing their thoughts in a way
21 that's -- is not consonant with their
22 best interest. That's what this slide is
23 about, so --

1 Q. Let me introduce another
2 exhibit.

3 A. Okay.

4 Q. This will be Exhibit 34.
5 (Exhibit 34 was marked for identification
6 and is attached.)

7 A. Could I back up to that last
8 one? Would that be all right?

9 Q. Sure.

10 A. Before we -- before we press on.
11 One of the things I'm just recalling, the
12 -- the -- the urgency of having that
13 particular slide there is that when
14 people take care of transgender persons,
15 children in particular, we always -- but
16 including adults. But -- but children
17 and adults, one always has to be on the
18 lookout for signs of sexual abuse because
19 it's a very -- it's a very commonly
20 reported comorbidity in persons who
21 experience these self-identifications.
22 It's not uncommon to discover that
23 they've suffered some form of abuse that

1 may be sexual but not necessarily sexual.
2 And so this is -- one of the things I
3 talk about in that slide is -- is for the
4 people who are care providers,
5 counselors, school administrators, to be
6 alert to that possibility.

7 So I'm sorry, we were going to
8 move on to the next one.

9 Q. Do you have the next exhibit?

10 A. And that is Exhibit 34?

11 Q. Yeah.

12 A. Okay.

13 Q. All right. This is a printout
14 from LifeSite, and the title is "Plastic
15 surgeon: Sex-change operation 'utterly
16 unacceptable' and a form of 'child
17 abuse.'" Right?

18 A. Yes.

19 Q. And it says, "Dr. Patrick
20 Lappert, a Catholic deacon in Alabama,
21 says changing a person's sex is a lie and
22 also a moral violation for a physician."
23 Right?

1 A. Yes.

2 Q. And you hold those views --

3 A. I do.

4 Q. -- correct?

5 A. I do.

6 MR. KNEPPER: Objection, form,
7 scope.

8 Q. Go to page 2.

9 A. Okay.

10 Q. This was published in September
11 2019; right?

12 A. Yes.

13 Q. This is reporting on you
14 appearing on a broadcast of something
15 called the "Relevant Radio's Trending
16 With Timmerie."

17 A. Yes.

18 Q. Right?

19 A. Yes.

20 Q. You made that appearance; right?

21 A. On the radio, yes.

22 Q. Okay. Look -- look to the fifth
23 paragraph on page 2.

1 A. Okay.

2 Q. It says, "He called it 'utterly
3 unacceptable' on moral grounds for a
4 plastic surgeon, because it disregards
5 the surgeon's call to balance respect for
6 both form and function of the body in his
7 or her work."

8 A. Right.

9 Q. Right?

10 A. Yes, sir.

11 Q. You don't deny saying that;
12 right?

13 A. Right. You should understand,
14 though, that the use of the term "moral
15 grounds" here is strictly from the
16 standpoint of my training as a plastic
17 surgeon. I'm not using this as a
18 platform for a religious discussion.
19 Speaking -- I'm speaking about form and
20 function, which are both very crucial to
21 an understanding of what plastic surgery
22 means.

23 And again, that speaks to the

1 end of plastic surgery, which is -- when
2 you're speaking about reconstructive
3 surgery, it's the restoration of form and
4 function. And these operations lack
5 moral basis precisely because they
6 destroy essential human functions for the
7 sake of achieving a cosmetic result,
8 which is morally unacceptable. And I say
9 that without reference to any religious
10 teaching. This is strictly my training
11 as a plastic surgeon, morally
12 unacceptable. And from the first moments
13 of my training as a reconstructive
14 surgeon, that was drilled into me, that
15 if you're planning a reconstructive
16 operation and it involves the movement of
17 tissue on the patient's body, you never
18 do something that's going to compromise
19 or destroy an essential human function.

20 You may challenge that function
21 a little bit, as you do, for example, in
22 a radial forearm flap, the same flap
23 that's used to recon- -- to construct a

1 phalloplasty. I've used that flap many
2 times to reconstruct head and neck cancer
3 defects, the same neurotized vascular
4 flap. And I would never dream of using
5 that flap, for example, if I was going to
6 compromise hand function. So it obliges
7 me to be careful, to make sure that when
8 I raise the flap, I don't harm the blood
9 supply to the hand. That's an example of
10 that.

11 In the example of transgender
12 surgery, by definition, you're destroying
13 fertility for life, which is an immoral
14 act in the eyes of plastic surgery as I
15 learned it through 30-plus years of
16 training.

17 Q. I understand. Let me just ask
18 you about the next two paragraphs --

19 A. Okay.

20 Q. -- of this article.

21 A. Okay.

22 Q. Then it says: "Regarding
23 children, Lappert said, sexualizing them

1 at a young age with these ideas is
2 grooming them for later abuse. 'It's
3 atrocious,' he said. 'And no one even
4 knows how that's going to play out.
5 There's no body of scientific evidence to
6 even support the safety of doing that to
7 children. But it's being done.'" Right?

8 MR. KNEPPER: Objection, form,
9 scope.

10 A. Okay. So, let's go through
11 that. So in this case -- we talked about
12 multiple uses of the word "grooming." In
13 this case, the abuse that they're -- it's
14 grooming them for is the abuse we just
15 finished discussing, what I consider to
16 be the abuse of transgender medicine and
17 surgery and what it does to the life of
18 that child. So that's the abuse I'm
19 referring to here. I'm not speaking
20 about this in terms of sexual abuse, I'm
21 speaking about in terms of
22 medical/surgical abuse of a child. So if
23 you get a child -- if you sexualize a

1 child's thinking and encourage them to
2 believe, for example, if -- if -- if I --
3 and I don't want to take up your
4 remaining time, but we can go into it in
5 more detail if you wish. But the point
6 I'm making here is this is grooming them
7 for medical and surgical abuse.

8 Q. Okay.

9 MR. TISHYEVICH: We can go off
10 the record.

11 THE VIDEOGRAPHER: This is the
12 end of Media Unit 6. We are off the
13 record at 5:07 p.m.

14 (Break taken.)

15 THE VIDEOGRAPHER: This is the
16 beginning of Media Unit No. 7. We are on
17 the record at 5:14 p.m.

18 Q. (By Mr. Tishyevich) Doctor,
19 that's all the questions I have for you
20 today. Thanks for your time.

21 A. Thank you. This was my first
22 ever deposition, and you were very kind
23 to me. Thank you for that.

1 Q. Okay.

2 MR. TISHYEVICH: All right.

3 Mr. Knepper?

4 MR. KNEPPER: Yeah, I'm ready to
5 go. I'm sorry. I actually had you
6 turned down, because when I put you on
7 mute, I could still hear Lane and Andrew.
8 I thought I saw their lips moving.

9 THE COURT REPORTER: Yeah, he
10 said he was finished asking questions.

11 MR. KNEPPER: Oh, I'm sorry. I
12 didn't hear that. I'm sorry, Dmitriy. I
13 apologize. I had -- you know, Lane
14 and -- and Andrew were talking to one
15 another, and so I was -- I had to turn
16 down my speaker.

17 So I guess why don't we -- why
18 don't we take a -- I've got 4:15. Why
19 don't we take a 15-minute break, and then
20 I'll see if I have anything on redirect,
21 and we'll come back at I guess it would
22 be 6:30 your time, Dmitriy?

23 MR. TISHYEVICH: Yeah.

1 MR. KNEPPER: Okay.

2 MR. TISHYEVICH: Sounds good.

5 (Break taken.)

6 THE VIDEOGRAPHER: We are back
7 on the record at 5:29 p.m.

8

9 EXAMINATION BY MR. KNEPPER:

10 Q. Dr. Lappert, I wanted to ask you
11 a couple of questions about your CV and
12 your biography.

13 A. Okay.

14 Q. On your biography, you identify
15 yourself as the Specialty Leader for
16 Plastic and Reconstructive Surgery, the
17 Office of the Surgeon General - United
18 States Navy, from 1997 to 2002. Could
19 you describe what that position involved?

20 A. Yeah. So I advised the Surgeon
21 General, first of all, with regard to the
22 selection of physicians for advanced
23 training in plastic surgery. I also

1 advised the Office of the Surgeon General
2 on policy matters pertaining to the
3 movement of patients and the availability
4 of services in the various treatment
5 facilities. I also advised him on policy
6 relating to coverage of particular
7 medical problems versus sending them out
8 into the community for care or declining
9 care.

10 So part of it was resource
11 management, part of it was personnel
12 management, and part of it was financial
13 management. And all the time, it
14 required to review the state of the
15 literature regarding reconstructive
16 surgery for combat-injured and as well as
17 medically retired personnel and other
18 retired people.

19 Q. And I -- I note that also in
20 your resumé is that from 1996 to 2002,
21 you were the Chairman of the Department
22 of Plastic and Reconstructive Surgery at
23 Naval Hospital Portsmouth. Could you

1 describe that -- that facility and its
2 role within the United States military?

3 A. Okay. Well, that -- as
4 department head, I was -- I had a five --
5 five staff plastic surgeons working for
6 me. I had I think seventeen hospital
7 corpsmen working for me. And we provided
8 services, reconstructive surgical
9 services on a referral basis from --
10 essentially from the eastern
11 Mediterranean all the way to Appalachia
12 and from North Carolina -- I'm sorry,
13 from -- from Maryland all the way down to
14 Florida. So all persons requiring
15 reconstructive surgery, including
16 combat-injured or other, would be
17 referred to us, people with congenital
18 deformities, peop- -- you know, pediatric
19 patients and -- and adults. And this was
20 in a -- in the facility which at the time
21 was the largest medical treatment
22 facility in -- I think in the world,
23 certainly in -- in the American purview.

1 I also -- I also established and
2 ran congenital craniofacial deformity
3 treatment. We ran a limb salvage
4 treatment that involved a great deal of
5 microvascular reconstructive surgery for
6 wounds, cancer, that sort of thing. We
7 also established the -- the wound care
8 center for that facility, and that --
9 again, we served that large catchment
10 area with advanced wound care services.

11 Q. Dr. Lappert, you served as a --
12 as a plastic and reconstructive surgeon
13 for the United States Navy. Is that
14 correct?

15 A. Correct.

16 Q. And you also served as a plastic
17 and reconstructive surgeon in private
18 practice. Is that correct?

19 A. Correct.

20 Q. Could you describe the -- or
21 contrast or describe the similarities and
22 differences in those two practices.

23 A. Certainly. Well, so both

1 practices involved both reconstructive
2 surgery and aesthetic cosmetic surgery.
3 But the difference is that in the
4 military, because of the nature of the
5 requirements, the experience level grows
6 much more rapidly in the military than it
7 does in the civilian world. So within
8 the first couple of years of my practice
9 as a reconstructive surgeon in the Navy,
10 I was doing the most advanced
11 reconstructive procedures, such as the
12 mi- -- the neurotized microvascular flap
13 operations that are often used, for
14 example, in the phalloplasties of
15 transgender surgery, or the perineal
16 vaginal reconstruction for cancer, same
17 operations that are used in the
18 vaginoplasty for transgender
19 self-identified persons. So a very
20 advanced complexity.

21 In fact, when I sat for my
22 boards, my oral boards, we had to present
23 ten selected cases that the board

1 selected, and both of my examiners were
2 startled at the level of complexity for a
3 second-year person out of training, doing
4 craniofacial surgery, free flap
5 operations, massive limb salvage surgery.
6 So that's the distinct difference, what
7 you get in civilian versus what you get
8 in the military. But both of them
9 involved reconstructive as well as
10 aesthetic cosmetic surgery.

11 Q. Sure. Now earlier, you were
12 asked about whether you had performed
13 certain procedures in the context of
14 transgender surgery. Is that correct?

15 A. Yes, sir.

16 Q. And your answer was that you had
17 not. Is that correct?

18 A. That's correct.

19 Q. Have you done those procedures
20 in the context of your practice of
21 plastic surgery?

22 A. I have.

23 Q. Could you describe that --

1 those -- those circumstances.

2 A. Well, as an example, a -- a very
3 memorable case, a patient with what's
4 called Fournier's gangrene, where
5 essentially, they had a massive
6 uncontrollable infection of the perineum
7 that destroyed the scrotum, destroyed
8 major portions of the penis, required
9 what amounts to a reconstructive
10 phalloplasty/scrotoplasty to reconstitute
11 them after a long period of wound care.
12 But the -- the operations to reconstruct
13 the urethra is the same operation that's
14 used to construct the urethra in a
15 phalloplasty or construct the urethra in
16 a metoidioplasty, same operations
17 involving local flaps, mucosal grafts,
18 tubularized flap operations. All of
19 those are the same. Just the indication
20 for the surgery is reconstructive rather
21 than the surgeries for transgender.

22 Same thing with the
23 vaginoplasty. Again, often --

1 oftentimes, reconstruction for radiation
2 injuries secondary to management of
3 vaginal -- vaginal perineal malignancies
4 that require removal of large areas of
5 soft tissue, again reconstruction of the
6 -- the perineum, the external genitalia,
7 the vaginal introitus, the vaginal canal,
8 same operations using flaps, grafts to
9 reconstruct as are used in the
10 transgender surgery world.

11 Q. So, do you feel that your
12 professional experience and
13 qualifications allow you to comment on
14 the -- the medical operations involved in
15 surgery for a transgender individual?

16 A. Yes. I'm -- I'm very familiar
17 with all of those operations.

18 Q. And -- and you've performed
19 those operations?

20 A. Yes, I have.

21 Q. Okay. Just not in the context
22 of gender transition?

23 A. That's correct.

1 Q. Okay. There was a -- there was
2 a brief question, and -- and we didn't
3 get back to it, about one of the articles
4 on your CV on breast reconstruction. Is
5 that -- is that correct?

6 A. Right. Yeah, that's one of my
7 listed articles. That's right.

8 Q. Great. Did you want to -- did
9 you want to say more about that article?

10 A. Yeah. So, that's -- was really
11 my entrance into the breast
12 reconstruction world. That actually
13 started when I was still a general
14 surgeon and I was collaborating with a
15 plastic surgeon, and we examined the
16 surgical planning for mastectomy in the
17 setting of breast cancer or other causes
18 and -- and the surgeon's role in
19 designing those operations to get the
20 best possible outcome. And it was
21 actually a seminal article, up until
22 recently was the most quoted article in
23 the literature on breast reconstruction.

1 And that was actually the first article
2 that spoke about conservation surgery in
3 surgical planning for the treatment of
4 breast malignancies or other breast
5 problems.

6 Q. Dr. Lappert, you were asked
7 questions about the policy or position
8 statements of several professional
9 organizations. Do you recall those
10 questions?

11 A. I do.

12 Q. Did those exhibits or any of the
13 questions change your opinion that
14 affirmative hormonal treatment and
15 surgery remains unproven and
16 experimental?

17 A. It has not changed my opinion.

18 Q. You were asked questions about
19 the evidence supporting the provision of
20 hormonal therapy and surgical
21 interventions for the treatment of gender
22 dysphoria. Is that correct?

23 A. Yes.

1 Q. Were any of the questions or any
2 of the studies that were presented to
3 you, did they change your opinion that
4 the existing medical evidence supporting
5 those interventions is of very low
6 quality and has methodological defects?

7 A. That did not change my opinion
8 about those, no.

9 Q. And just to clarify, what is
10 your opinion about the -- about the
11 current state of the evidence supporting
12 hormonal therapy for treatment of gender
13 dysphoria?

14 A. My opinion is that all of these
15 published studies that are used to
16 support or to justify the use of puberty
17 blockade, cross-sex hormones, or
18 transgender -- gender-affirming surgery
19 are of the lowest quality scientific
20 evidence and are not sufficient to
21 support care and interventions that have
22 such far-reaching and lifelong effects on
23 the patient.

1 Q. Are your opinions on that -- on
2 that issue in this case based on anything
3 other than your review of the scientific
4 and medical literature and your training
5 as a -- as a physician?

6 A. No, they're not.

7 Q. Dr. Lappert, you were asked
8 about off-label use of Botox for certain
9 muscle -- muscle groups. Is that
10 correct?

11 A. Yes, I was.

12 Q. And you -- and you described --
13 and you stated that you've actually used
14 Botox off label for treatment of those
15 muscle groups before that was approved by
16 the FDA. Is that correct?

17 A. That's correct.

18 Q. But you have also said that you
19 believe that it is significant and -- and
20 relevant to this case that the use of
21 hormone and puberty blockers for
22 treatment of gender dysphoria is
23 off-label. Is that correct?

1 A. Yes.

2 Q. Could you disting- --
3 distinguish between why you hold the view
4 that off-label uses of some
5 pharmaceuticals is acceptable by a -- by
6 a physician and when you consider that to
7 be unacceptable by a physician?

8 A. Right. So, the off-label use of
9 medications when there's a low risk to
10 the patient or that the -- the possible
11 adverse effect may be brief and that a
12 favorable result is likely where risk is
13 low, then that's justifiable to go off
14 label with medications. But when you're
15 -- when you're talking about significant
16 risk to the patient and irreversible
17 changes, that the off-label use places a
18 tremendous burden on the practitioner to
19 -- to have scientific evidence to support
20 his decision to do that. And to not have
21 sufficient evidence when doing that is a
22 -- is a -- is a great difficulty in terms
23 of consent and in terms of just general

1 medical/surgical decision-making.

2 So the distinction is the
3 risk/benefit equation. How much risk are
4 you placing the patient under, is it
5 irreversible, and is the benefit so great
6 that it's worth taking the risk.

7 Q. Sure. Just to follow up, and
8 these are going to be my final questions,
9 is it your view that there are no -- and
10 does it continue to be your view that
11 there are no -- currently no competent --
12 competently conducted long-term,
13 peer-reviewed, reliable, and valid
14 research studies documenting the number
15 or percentage of patients who receive
16 gender-affirming medical interventions
17 who are helped by such procedures?

18 A. It's still my position that --
19 that the medical literature does not
20 support those interventions of medical
21 and surgical treatment for
22 self-identified transgender persons.

23 Q. Is it still your view that there

1 are no published, reliable, and valid
2 research studies that document a valid or
3 reliable biological, medical, surgical,
4 radiological, psychological, or other
5 objective assessment of a -- of a
6 patient's gender identity or gender
7 dysphoria?

8 A. Yes. It's still my position
9 that there are no tests that will confirm
10 or refute the diagnosis of transgender, a
11 diagnosis made by the patient. There's
12 no way to test for that.

13 Q. All right. Is it still your
14 view, after the evidence and the
15 questions that you've been presented,
16 that an unknown percentage of patients
17 who present with gender dysphoria also
18 suffer from mental illnesses that
19 complicate and may distort their
20 judgments and perceptions of gender
21 identity?

22 A. Yes. The -- the world
23 literature demonstrates a consistent and

1 significant level of comorbidities,
2 including severe anxiety, major
3 depression, self-harm. The patient is
4 very likely to be on the autism spectrum.
5 Suicidal ideation. And -- and the world
6 literature supports that. So -- and
7 those are -- those are serious issues,
8 not only in terms of decision-making, but
9 even on the question of consent and
10 competence for consent.

11 Q. Just one -- one more thing I
12 wanted to follow up with. Your testimony
13 -- we didn't cover this, but I want to
14 make sure that it's still your view that
15 medical treatments may differ
16 significantly by sex according to your
17 chromosomal assessment but not based on
18 your gender identity and that
19 misinforming physicians of a patient's
20 biological sex could have deleterious
21 effects on treatment for medical
22 conditions?

23 A. Yes, that's correct. And when

1 we discuss the issue of misgendering,
2 that's what we were talking about. We
3 were talking about placing the patient at
4 risk. If you're having a -- a discussion
5 or conversation about medical
6 decision-making, you have to distinguish
7 between biological male and female
8 because you run -- there -- there are
9 illnesses that predominate in females
10 that don't exist in males; there are
11 conditions that affect males that do not
12 affect females, and you have to know that
13 if you're going to offer care. But
14 again, that hasn't been changed by -- by
15 what I've seen or heard here today.
16 That's still -- is still the case.

17 Q. Okay. And it's still your view
18 that the use of hormones and surgery to
19 treat gender dysphoria is not supported
20 by the relevant scientific communities as
21 discerned by your literature review and
22 your training as a physician in
23 reconstructive and plastic surgery?

1 A. Yes.

2 MR. KNEPPER: Those are my
3 questions. I don't think I have anything
4 else. Did you have follow-ups you
5 wanted, Dmitriy?

6 MR. TISHYEVICH: Very, very
7 briefly.

8 MR. KNEPPER: Okay.

9
10 EXAMINATION BY MR. TISHYEVICH:

11 Q. Doctor, you were just asked
12 about your views on why it's okay to use
13 Botox off-label but you have a different
14 view of puberty blockers. Do you recall
15 that?

16 A. I do.

17 Q. And one of your considerations
18 is the risk/benefit profile of Botox;
19 right?

20 A. Right.

21 Q. Do you know what a black box
22 warning is, Doctor?

23 A. Yes.

1 Q. It's the strongest warning that
2 the FDA can require; right?

3 A. That's -- that's right.

4 Q. And that warning is typically
5 only used if studies indicate that the
6 drug carries a significant risk of
7 serious or even life-threatening adverse
8 effects; right?

9 A. Yes.

10 Q. Do you know that Botox has a
11 black box warning?

12 A. Yes, I do.

13 Q. It's for distant spread of toxin
14 effect; right?

15 A. Yes.

16 Q. And the use of Botox has -- has
17 resulted in reports of life-threatening
18 injuries and death; right?

19 A. I'm even familiar with the case
20 reports that reported that. Yes, sir.

21 Q. Okay. That's all I've got for
22 you.

23 MR. KNEPPER: Okay. Thank you.

1 Dr. Lappert.

2 THE WITNESS: Thank you.

3 MR. KNEPPER: We're finished
4 with your testimony.

5 Thank you, Dimitry. Thank you,
6 Lane. Thank you, Andrew.

7 We can go off the record.

8 THE VIDEOGRAPHER: This is the
9 end of Media Unit No. 7. We are off the
10 record at 5:47 p.m. Thursday, September
11 30th, 2021, and this concludes today's
12 testimony given by Dr. Patrick Lappert.

13

14 END OF DEPOSITION

15 (5:47 p.m.)

16

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23

1 C E R T I F I C A T E

2 STATE OF ALABAMA)

3 COUNTY OF JEFFERSON)

4 I hereby certify that the above
5 and foregoing proceeding was taken down
6 by me by stenographic means, and that the
7 content herein was produced in transcript
8 form by computer aid under my
9 supervision, and that the foregoing
10 represents, to the best of my ability, a
11 true and correct transcript of the
12 proceedings occurring on said date at
13 said time.

14 I further certify that I am
15 neither of counsel nor of kin to the
16 parties to the action; nor am I in
17 anywise interested in the result of said
18 case.

19 /s/ Lane C. Butler

20 LANE C. BUTLER, RPR, CRR, CCR

21 CCR# 418 -- Expires 9/30/22

22 Commissioner, State of Alabama

23 My Commission Expires: 2/11/25

1 John G. Knepper, Esquire

2 john@knepperllc.com

October 13, 2021

4 RE: Kadel, Et Al v. Folwell

5 9/30/2021, Patrick Lappert, M.D. (#4814384)

6 The above-referenced transcript is available for
7 review.

8 Within the applicable timeframe, the witness should
9 read the testimony to verify its accuracy. If there are
10 any changes, the witness should note those with the
11 reason, on the attached Errata Sheet.

12 The witness should sign the Acknowledgment of
13 Deponent and Errata and return to the deposing attorney.
14 Copies should be sent to all counsel, and to Veritext at
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17 Return completed errata within 30 days from
18 receipt of transcript.

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22 Yours,

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1 Kadel, Et Al v. Folwell

2 Patrick Lappert, M.D. (#4814384)

3 E R R A T A S H E E T

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24 Patrick Lappert, M.D.

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1 Kadel, Et Al v. Folwell

2 Patrick Lappert, M.D. (#4814384)

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, Patrick Lappert, M.D., do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

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Patrick Lappert, M.D.

Date

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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